### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06001 Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death -Month **Physician** 22 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death / 4c. County of Death Examiner more If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Ye Birthplace (State or Foreign Gountry) **Funeral** Deys Hours Months 266--64-4628 1 M 20 F Yrs. Director Usual Residence of Decedent with the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits herns 23a or 28a-f show ner must be notified at 1 Yes 2 No Director IMOr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth , Funeral 0 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, pernit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or flan eny Injury or other treumatic event, tre Medical Examinan hans. Bleck, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 Ø No Specify: speciny: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Baitimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) d ,0 20b. Ptece of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removet from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hame ner a S Joseph Balto North Ave 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, above, or heart spilure. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** Medical Immediate Cause (Finel disease or condition resulting in death) even month namores Examiner Dua to (or es a consequence of): Examiner physician and the buriel-transit The law requires that the deeth certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): 980 P.0. Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown nolon of Vital Records, à 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? No No 1 Yas 1 TYes Physician: 25. Was case referred to medical examiner? Be funansi director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 1 Yes 25 No 1 Inpatient Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 27. Manger of Death 1 2 Natural 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) Injury at Work? Division or Attanding 5 Pending investigation njury To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No **2** ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 THomicide Contifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and mannar as stated. Discontinuous Continuous Continuou edical 29a. Certifier

Registrar

State

29b. Signature and little of certifier

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2000

no completed cause of death (Item 23a) (Type, Print)

32. Robustruc's Dignatura

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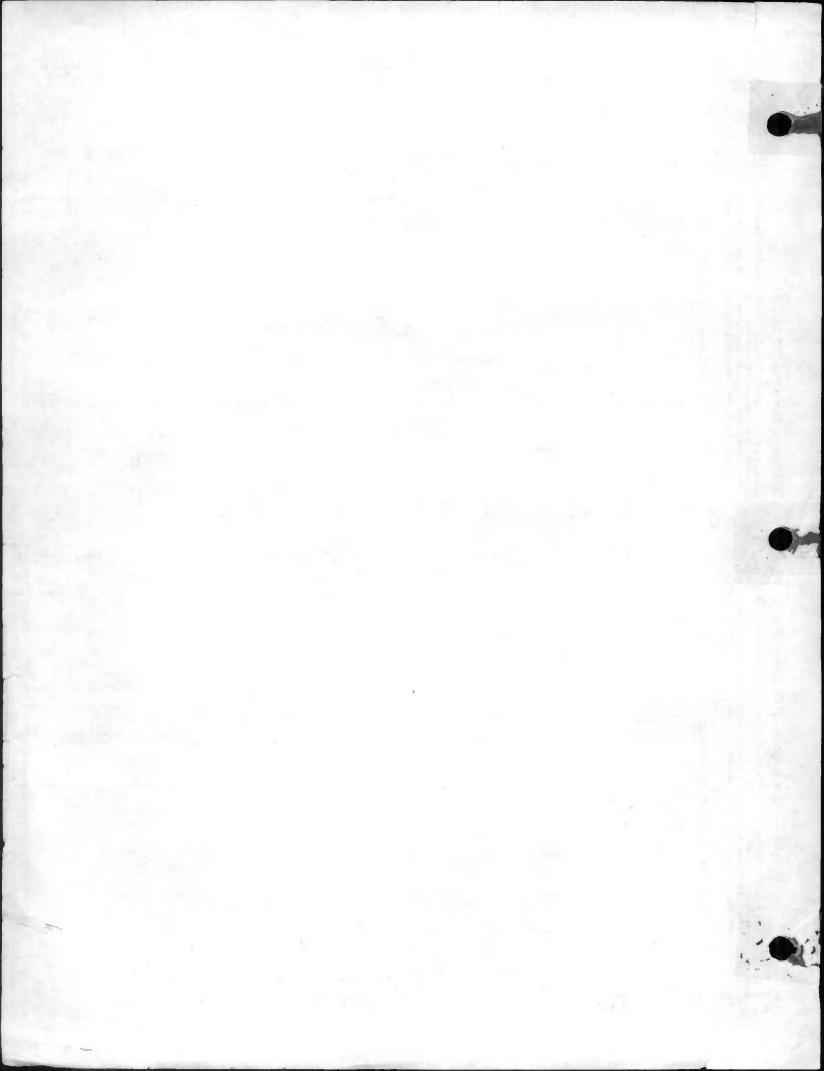
29c. License number

Anjore

land

Mary

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06002 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth 2000 12:25 pm February Ella V. Jaworski 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, giva street end number) 4c. County of Death Carroll Carroll County General Hospital Westminster If Undar 1 Yaar If Undar 24 Hrs. Hours Min. Birthplace (State or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer, 1 □ M 2 K F Months Days MD January 13, 1923 216-14-8282 Usual Residence of Decedent 10d. Insida City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21158 1246 Emerald Ridge Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: white 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) own home Housewife 17. Fethar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frances Duchesney Ruby Watts 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1246 Emerald Ridge Road, Westminster, MD 21158 Edward Jaworski - husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/26/00 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Sarvice Licensee CAFA, Stephen D. Lohrmann, P.A. Laura (. Hardes) 8717 Green Pastures Drive, Towson, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervai Between Onsat and Death Immediate Cause (Final GASTROINTESTINAL BLEED disaase or condition resulting in death) Due to (or as a consequence of) GASTRIC ULCER YEARS IRRHOSIS OF THE LIVER Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy 1 Yes 2 □ No 1 Tes 2 No 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Pinpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examiner

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ils certificate has I

the Hospital or Attending Physician: in 24 hours after death.

The Funeral Director: After this certifical pletaly filled in by the funeral director.

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Physician/Medical

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Certification:

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The law requires that the dasth certificate be executed

Division of Vital Records, P.O. Box 68760

parmit. Page Department of Important: If any Injury or once.

**Physician** 

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Funeral

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**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. Inter if item 27 is marked other than "natural", or itema 23a or 28a-f show ary or other treumatic event, the Medical Examiner must be nothed at

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Diseasa or Injury that Initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) investigation

28b. Tima of

28c. Injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d Date signed (Month, Dev. Year)

29b. Signature and title of certifier Cu

5 Pending

D0044362

2-23-2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

A. GIANGERUSO, M.D ENRICO 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

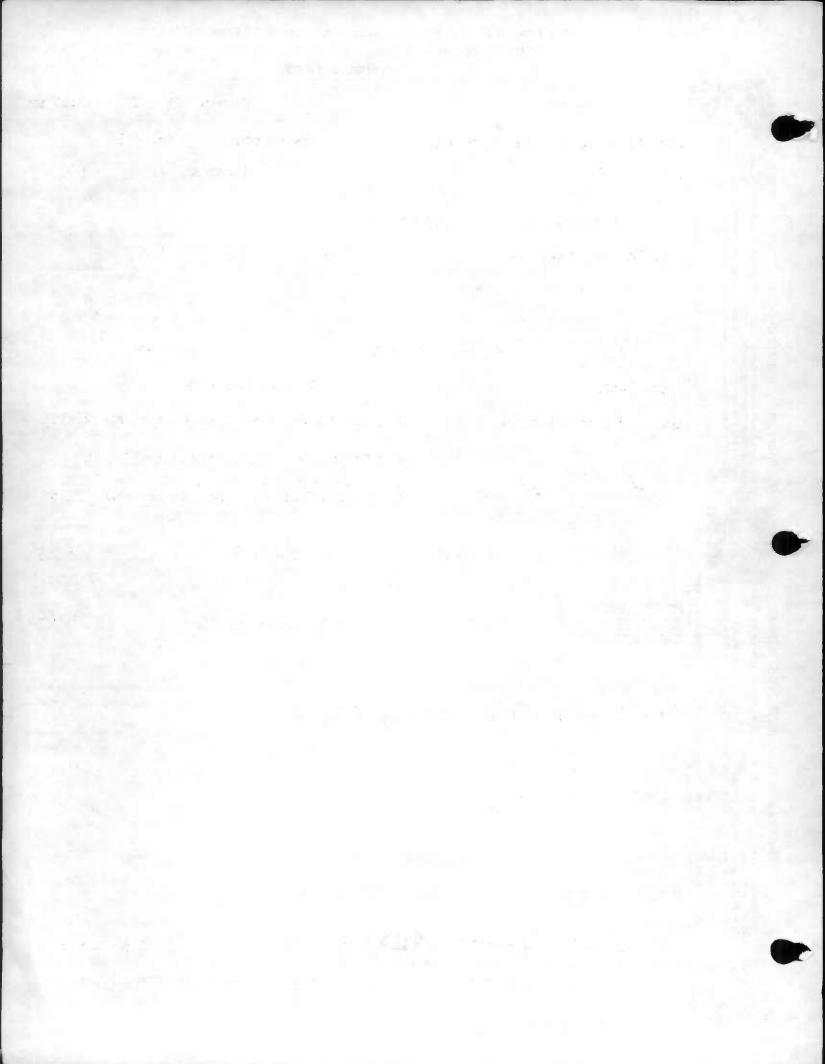
200 MEMPRIAL AVE. WESTMINSTER, MD

State Registrar

**DHMH 16 Rev 6/95** 

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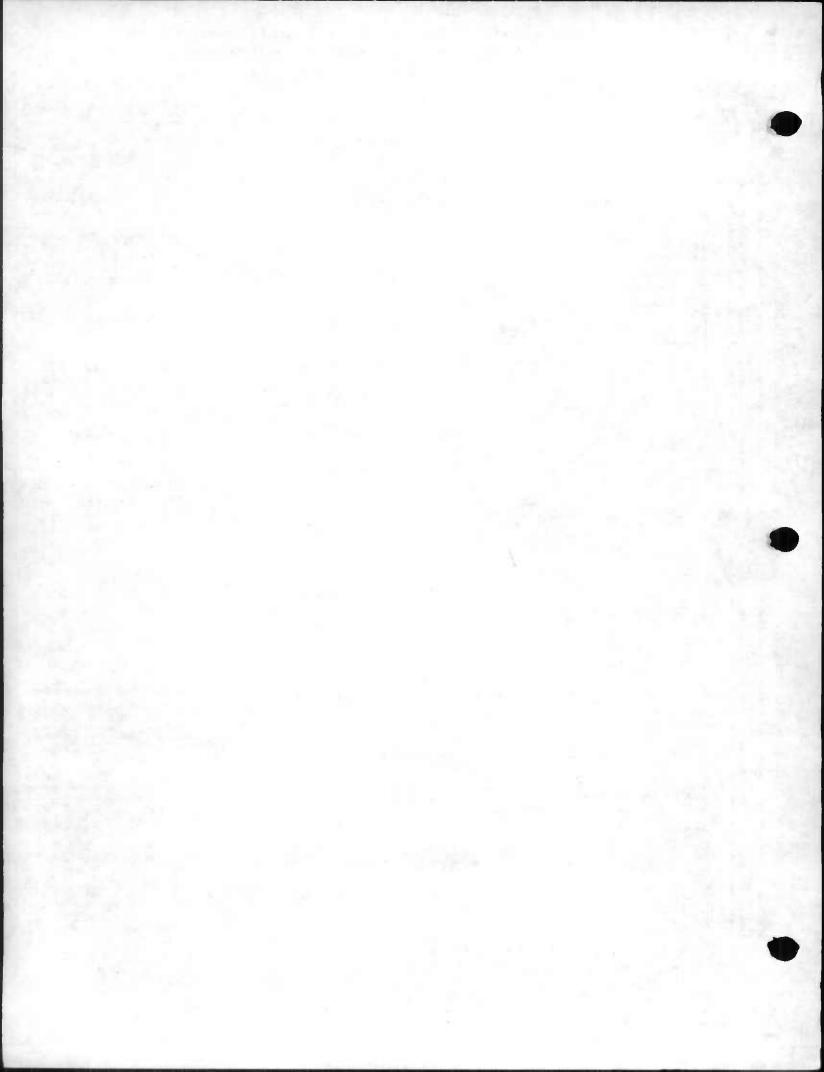
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		State of Maryla		partment o		d Mental H	lygiene (	06003
Physician	Decedent's Name (First, Middle, Las	George V.				2. Dete of Month		3. Time of Death  Year  OOO 10:15 am
/Medical Examiner	4a Facility Neme (If not Institution, give NORTH ARU		OSPIT	AL		Or Location of De		
Funeral Director	216 24 6499	7. Age (In yn 70)		y) If Under 1 \ Months D		Min. (Month,	Birth Day, Yeer) t 14,1929	Birthplece (State or Foreign Country)     Maryland
Waryland Maryland at a show led at	Usuel Residence of Decedent  10a. Stete 10b. County  Maryland Anne Arn		City, Town or					10d. Inside City Limits 1 ☐ Yes 2X No
recognition of the maryland the death with the Maryland the death with the Maryland the research above the research of the control of the con	10e. Street end Number 1204 Watervale C			10f. Zip Co	nde .122		10g. Citizen of V	
-h - 5 22 5	11. Meritel Status  1 □ Never Merried 2 □ Merried  3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ever in Amed Forces?  1⊠ Yes 2□ No KC If Yes, Give Year or Dates: COnf	rean	3. Wes Decedent If Yes, apecity	of Hispenic Origin Cuban, Mexican, F No Specify:	? (Specify Yea or Puerto Rican, etc.)	No- 14. Rac Blac Specify	e - American Indien, ck, White, etc. White
215. 215. e	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation	16a Dec	cedent's Usual Ove kind of work of the DO NOT use r	eccupation lone during most of etired)	f working	16b. Kind of Bu	usiness/Industry
24 Mental	12th 17. Father'a Name (First, Middle, Last)		Le	etter Pr		Neme (First, Mid	dle, Maiden Sumem	nting e)
Maryle Maryle d 2 should the and Maryle Tile merite treumetic treumetic	19e. Informant'a Neme/Reletionship (7) Diane Ostrowski				treet end Number o	or Rurel Route Nu	mber, City or Town,	Stele, Zip Code) ryland 21122
altimore, Maryland mit. Pages 1 and 2 should be file partment of Health and Mentel Hyportant: if Item 27 is marked other y Injury or other treumstic event.	20e. Method of Disposition  1  Burlel 2 Cremetion 3 4 Donation 5 Other (Specify	20b.	Place of Dis	position (Neme remetory or other	of r plece)	Dete	20c. Location -	City or Town, State re, Maryland
Balti. Departmingorial any Injury Inj	21. Signature of Funeral Servica Licens			22. Name end A	ddress of Fecility	Gonce	Funeral	
Physician /Medical	23e. Part 1. Enter the discuss, or comp shock, or heert failure. List only o	olicetions thet caused the de						Approximete Interval Between Onset and Deeth
Examiner	disease or condition resulting in deeth)	a. Priece  Due to	(or es e cons	sequenca of):	Maci	dent		
68760, licate be executed physicien and is the burial-transit edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	Ç	(or as a cons		· ucc	0000		
I Records, P.O. Box 687 The law requires thet the death certificate tate has been signed by the attending physpage 2 should be detected for use as the completed by Physician/Medic	Pert II. Other significant conditions co	d	esulting in the	underlying caus	e given in Part I.	23b. [	Old tobacco use co	ntributs to the cause of death?
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The law requires th tate has been signed, page 2 should be d						_ P	/es en eutopsy erformed?	24b. Were eutopsy findings aveileble prior to completion of cause of deeth?
of Vital Re hystolen: The is his certificate ha il director, page To Be Com	25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient 2	ER/Outpat	ient 3 DOA	Other:	Death (Check or		1 Yes 2 No
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Hospital 24 hours Funeral fely filled	29a. Certifier 12 Certifying Phy one) 12 Medical Exam	reiclan: To the best of my kr iner: On the besia of examin end menner stated.	nowledge, de nation and/or	eth occurred et t investigation, in	he time, date and p my opinion, death	place, and due to occurred et the tir	the ceuse(s) end me ne, date end place,	enner as stated. end due to the cause(s)
To the within 2 To the comple	29b. Signeture end title of cartifier  Thum W	bamo		29c. L	a 386	7	29d. Dete signe	d (Month, Dey, Year)
10	30. Neme end address of person who comes was surely for the surely surel	MD 277He	nuna	Cula Fa	irm Ro	an Are	2/16 NOLD A	n
State Registrar  DHMH 16 Rev 6/95	31. Dete filed (Month, Dey, Year) FEB 2 4 200	32. Registrar's Sig		Soon	Ka			

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland & Department of Health and Mental Hygiene Certificate of Death AMEND ITEMS: #323 PART I, 27 PER MEO G781 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** KANE FEBRUARY 22, 2000 IAWANNA 18:19P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 1208 SHELLBANK ROAD BALTIMORE 8. Deta of Birth (Month, Day, Year) DEC. 21, 1970 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 1 M 2 KF 9 217-96-2574 Yrs. Director LAND **Usual Rasidence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. tnsida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nas 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 ROAD 21225 BANKS 14. Race - American Indian, Black, Whita, atc. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Never Married 2 Married 1 ☐ Yas 2 No 21215-0020 1 Yes 2 No Specify: þ Yes, Giva BLAC 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) L. Pages 1 and 2 should be filed with timest of Health and Mentel Hyglen tant; If Nem 27 is marked other the liury or other treumadic event, the 12 + #GRADE KEEPER HOUSING AUTHORIT Saltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be ANE MARIE SHANNON JAMES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARIE SHANNON (MOTHER) 712 FISK ROAD, BALTIMORE, MD. 21225 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from Stata CEMETERY 12-26-00 LANSDOWNE, MARYLAND 4 □ Donation 5 □ Othar (Specify) ZION 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licer 140 N. FULTON AVE. BALTIHORE MD, 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical CARDIOMYOPATHY, NOT OTHERWISE SPECIFIED Examiner Dua to (or as a consequence of): Examine physician and the burlst-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of). 68760 Physician/Medical Dua to (or as a consequence of). Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð The law requires 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page Yas 2 No 1 Yas 2 No of Vital Be 25. Was casa relarred to medicat 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 A Residence 6 Other (Specify) edical Certification: To 1XXYas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mariner of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division Affer or Attending 5 Pending invastigation settar death.

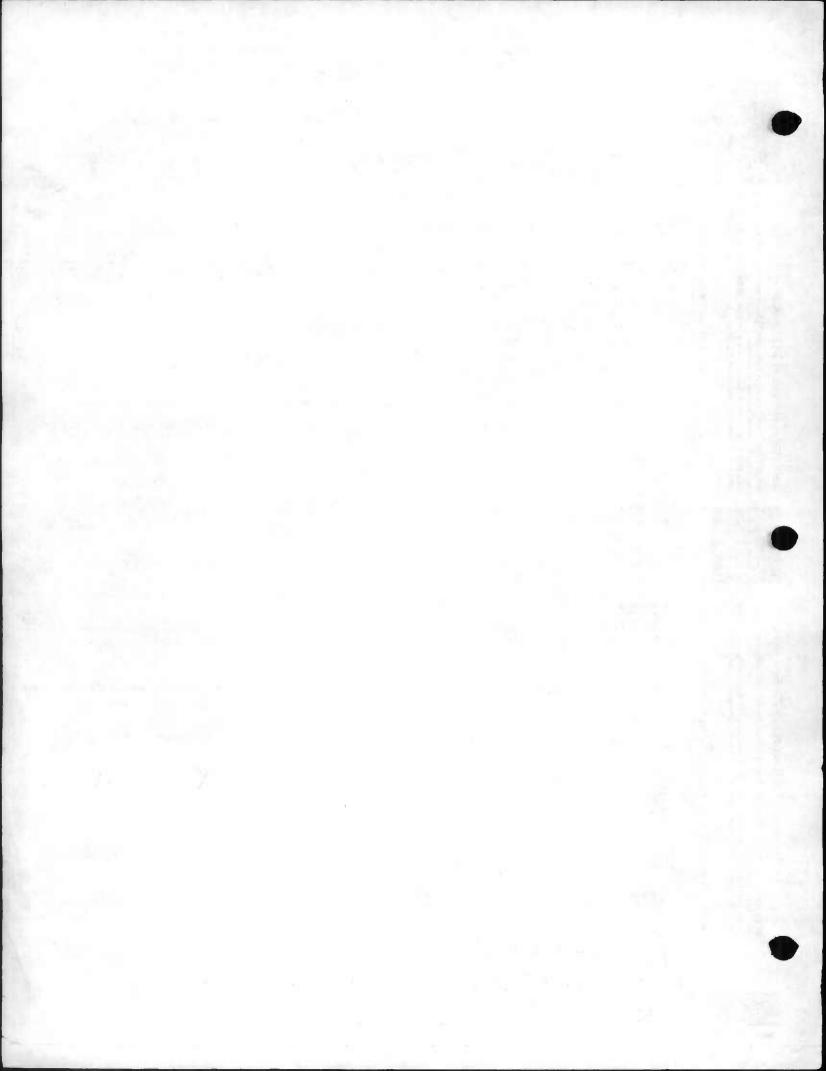
Director: After din by the fur 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The death occurred at the time, date and place, and due to the cause(s) and manner stated.

The death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month. Day, Year) O.C.M.E. FEBRUARY 23, 2000 completed causa of death (Item 23a) (Type, Print) MO M 111 Penn Street, Baltimore, Maryland 21201 31 Data filed (Month, Day, Year) 32. Registrar's Signatura State FEB 2 4 2000 2e was

**DHMH 16 Rev 6/95** 

Registrar



Piease Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 22, 2000 2:30 PM February John William Kuhn, Sr. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1613 Sulphur Spring Road Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20 F Yes 62 Director 219-34-0842 Aug. 7, 1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1613 Sulphur Spring Road 21227 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hyglene. other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed to Department of Heelth and Mentel Hygle. Importants: If them 27 is marked other then pilotry or other traumatic event, the page. 12 Designer Draftsman Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Stewart Hamilton Kuhn Marie Tribbe 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita M. Kuhn/ Wife 6309 Shipley Court, Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Dete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Md. Vet. Cem. Crownsville 2-28-2000 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. uanta () 4107 Wilkens Avenue, Baltimore, Maryland 21229 Homos 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, should be heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** MUSSIVE Upper 6-I he morrhage
Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Esophageal Varices

Due to for as a consequence of): attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? been s Completed 24a. Was an autopsy 21 No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 200 No 70 this After this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Attending 5 Pending investigation or Attending after death. Director: After 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletally filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

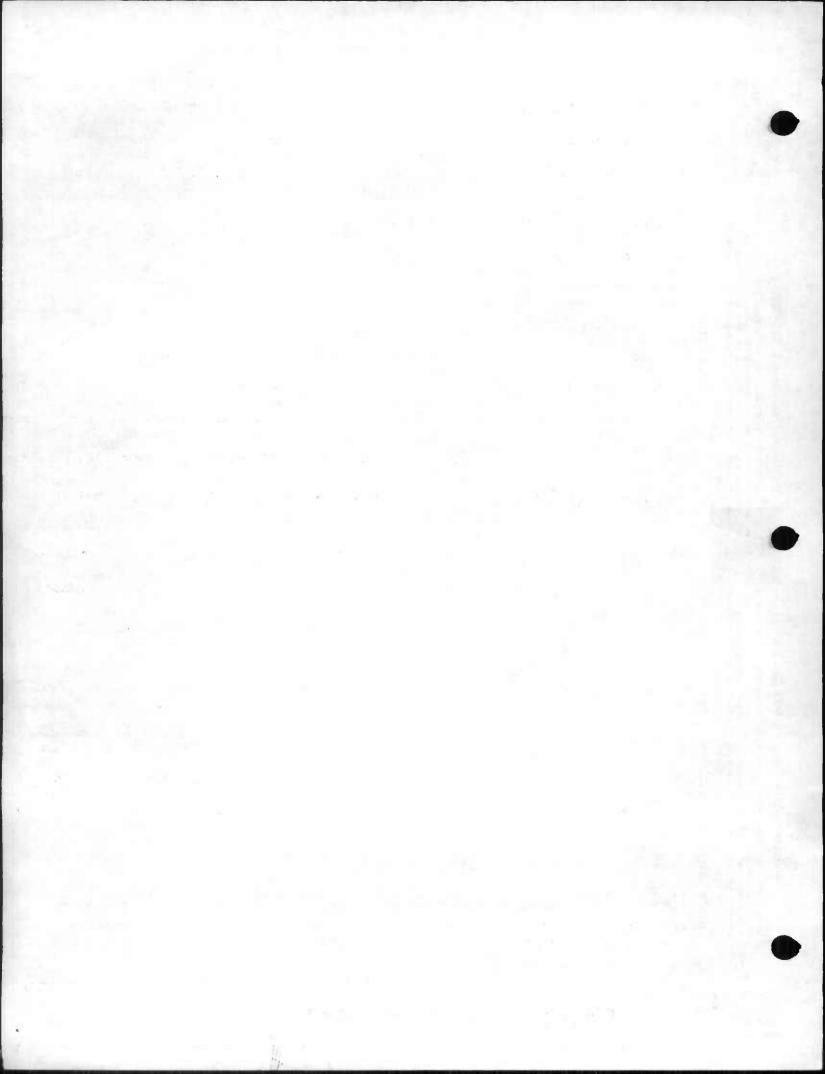
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MU Towalles & 00 rulo, D51018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Ave. 3421 Surte 230 Baltimore MD 21227 PINTO MD

State Registrar

DHMH 16 Rev 6/95

oaks

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Yaar IMCZAK : 25 Pm MARY JOAN EBRUARY 20 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth HOSPITAL BALTIMORE HARBOR CENTER N/A If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sax 8. Data of Birth (Month, Dey, Year) July 23, 1 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) Days Hours 1 □ M 200 F Months 216 09 3181 81 Maryland Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WYas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4114 Audrey Avenue 21225 U.S. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Giva 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: Specify. Year or Datas: 3℃ Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 9th 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Waclaw Dlabich Katazena Kalicynska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Jean Dabrowka / Daughter 661 Rhone Court Glen Burnie, Maryland 21061 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) Sacred Heart of Mary Cem. 2/23/00 Baltimore, Maryland 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 Part 1. Enter the disease, or complete ations that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List of the acouse on each line. Approximata tntarvat Between Onsat and Death Immediata Cause (Finel ARCTION 4 DAYS disaasa or condition rasulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 □ Unknown 24b. Wara autopsy lindings available prior to 24a. Was an eutopsy performed? completion of cause of death? 2 X No 1 Yes 25 No 1 Yes 26. Place of Deeth (Check only ona) Hospital: Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Day Year) 28b. Tima ol 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Yas 2 No

/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital

physician s the burial use signed by the a certificate or Attending Physician: this After Hospital or Attendin 24 hours after death.
 Funeral Director: Aft filled in by

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

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To

Examiner

Physician/Medical

Completed by

8

Certification: To

Medical

**Funeral** 

Director

show

384

Berns 23s or

"natural", or

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

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Important: If Itam 27 is any injury or other tra once.

**Physician** 

altimore, Maryland 21215-0020

25. Wes case relarred to medical 1 Yas 2 No 27. Mannar of Death 5 Pending invastigation 1- Natural 2 Accidant 6 Could not be detarmined 3 Suicida 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, larm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartitiar certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the causa(s) and mennar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one)

within 2 To the To the

M.D

29b. Signatura and titla of certifier

11980

29d. Data signed (Month, Day, Year)

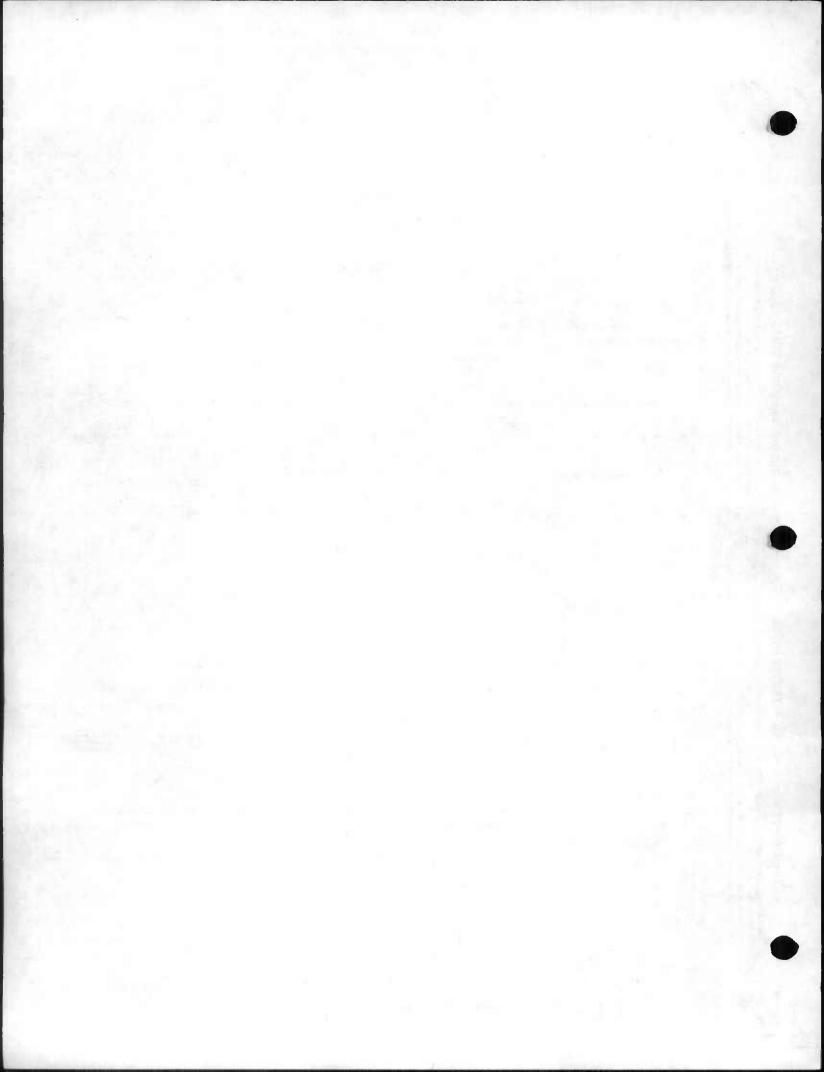
30. Nama and address of person who completed cause of death (flem 23a) (Type, Print)

STREET, MD-21225 HANOVER 3001 SOUTH 40571

State Registrar 31. Data filed (Month, Day, Year) FEB 24 2000

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 



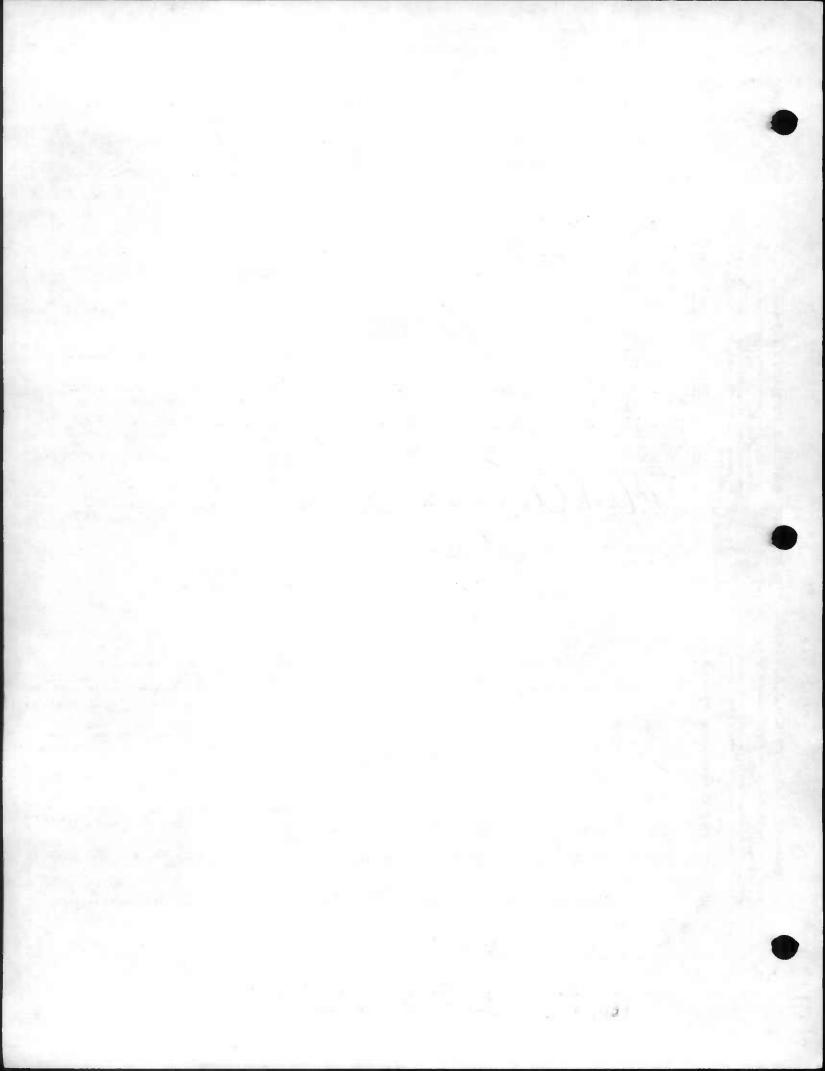
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtifica	te of	Death		Re	g. No.		00007
Dhuaisian	The Contribution of the Co	me (First, Middle, La	st)						2. Date	of Deat	1	Year	3. Time of Death
Physician /Medical	Leslie		Lee			M	arti	ı Jr.	Febr		17 200	00°	12:58PM
Examiner		(If not institution, giv		per)				lb. City, Towr	n, or Location of	Death	4c. County	of Death	
		th 48'th				Milade	I Year	Oundall		1010	Balt	imore	
Funeral Director	5. Social Security 219–32–6 Usual Residence	297	M 2 F	Age (In yrs.	Yrs.	Months			Min. July	of Birth oth, Day, 3 1		9. Birthple Counti Mary	
28a-f show notified at	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10	d. Inside City Limits
be notified at	Md.	Baltimo	re	Dun	dalk	101 7	in Code			146	og. Citizen of \	All at Court	1 □ Yes P □ No
23 0	702 Rai	lway Aven	ue				ip Code 21222	2			.S. of		•
Examiner must by Funeral	3 ☐ Widowed	rried 2 Married	12. Was Decede Armed Force 1 Wes 2 If Yes, Give Year or Date	es? □No 195	3	Was Deci If Yes, spi 1 Yes		ispanic Origir in, Mexican, f Specify:	n? (Specify Yes Puerto Rican, e	or No-		ce - America ck, White, e y: Whit	tc.
fight party	(So	15. Decedent's Ed	fucation		16a. Dece	dent's Us	ual Occup	ation during most o	f working		16b. Kind of B		
A, the Medical	Elementary/Sec		College (1-4	or 5+)	life.	Cle		during most o			Socia	l Secu	ırity
10 5 0		e (First, Middle, Last)						18. Mother's	s Name (First, I	Viiddle, N			
To F	Leslie		Lee		Marti	n Sr	•	Franc	cis		]	Pishal	lski
		Name/Relationship (	Type, Print)			1000			or Rural Route				
1 27 W		shalski (	Uncle )					th St.	. Dunda	-	_		
into If the into It in into		sposition  Cremation 3  Other (Specify			lace of Dispo emetery, crea Metr	matory or		;e)	Feb 21		altimo:		eryland
Importa	21. Signature of I	Superal Service Licer	0/0	1.	22	W.	Dabro		Chojnac				
nysician	23a. Part1. Enfer shock, or he	the disease, or compart failure. List only	plications that cau one cause on sac	sed the deat	n. Do not en	LOU5	Dunce of dyir	g, such es ca	ve. Bal ardiac or respire	to., etory erre	Md . 2		Approximata Interval Between Onset and Death
Medical caminer	Immediate Cause disease or condit resulting in death	ion	a Liver	Failu	re							3	Years
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ist-transit Examiner	Sequentially list of	onditions C	b. CILLII		r as a consec	nence of	).					- 1	
	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated ever	immediate derlying or injury	e. Alcoh	al abu	se							1	D'
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hed by the attendi detached for use y Physician/		ificant conditions o	ontributing to deat	n Dut not resi	uting in the u	ndenying	cause giv	en in Part I.	234		s 2 No		the cause of death?
should by									248	. Was ar	n autopsy ned?	avai con	re autopsy findings flable prior to apletion of cause eath?
ege C										1□ Ye	s 2 DNo	10	Yas 2 No
is certificate has director, page 2 fo Be Comp	25. Was case refe	erred to medicat						26. Place o	Death (Check	only one	B)		
· 6	axaminer?	340	Hospital: 1 Inp	atient 2	ER/Outpatier	nt 3 D	OA Oth	er: 4 Nurs	ing Home 5	Reside	nce 6 Doth	er (Specify)	Uncles
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rs after deeth.  el Director: After t led in by the funant Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	286. PIACE OF	Injury - At ho , etc. (Specif)	ome, farm, str	reet, facto	ry, office			ation (Str or Town		ber or Rural	Route Number,
Minin 24 hours are deem. To the Funeral Director: After completely filled in by the funar Medical Certification:	29a. Certifier (Check only one)	1⊠ Certifying Phy 2□ Medical Exam		s of examinal									
To the	29b. Signature an	d title of certifier	1			29	c. Licens	e number		29	d. Date signe	d (Month, D	Pay, Year)
	1	ee 1	1 CK	1	mu)		D 41	614		F	'ebruar	y 24,	2000
9		dress of person who	AQ20	nem) mees w	23a) (Type,		ito	March	Md. 21	236			
State	31. Date filed (Mo	rith, Day, Year)	32. Reg	istrar's Signa	ture	A. VVI	DR M	a /		- V			

DHMH 16 Rev 6/9!



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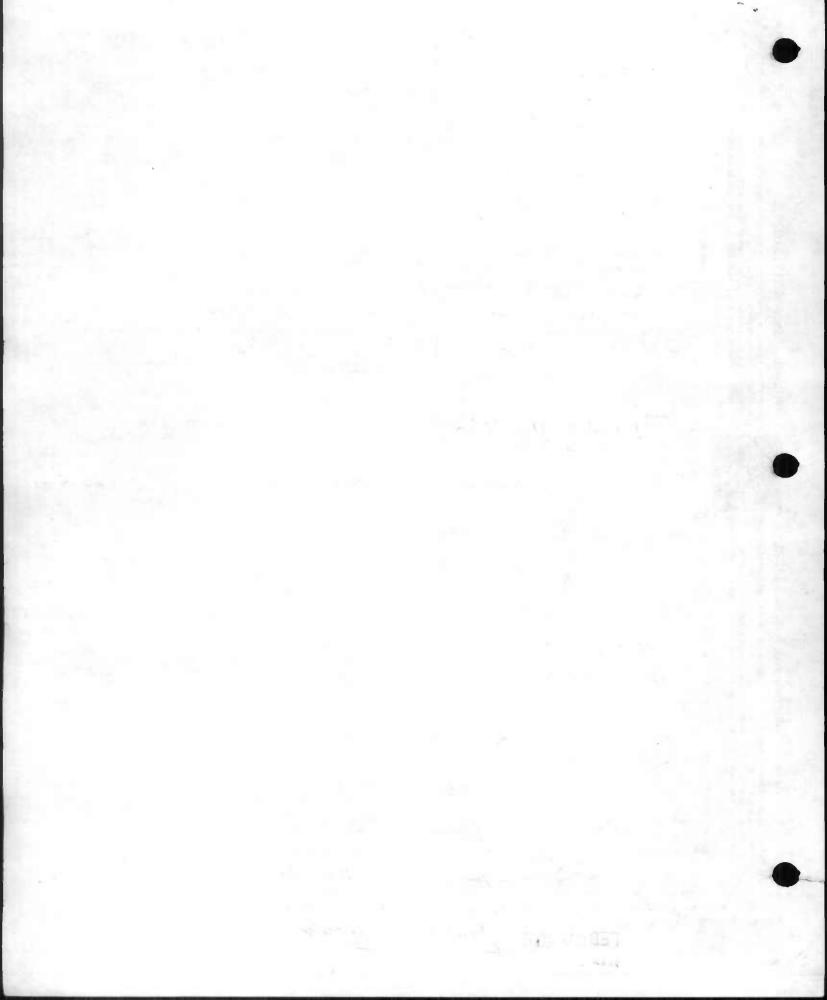
State of Maryland / Department of Health and Mental Hygiene 06008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 4b. City, Town, or Location of Death 4c. County of Death Crystal 1315 Megginson /Medical 4a Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6 Security Number H Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 6-17-85 Hospital 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Md . **Funeral** 1 M 2 KF 1 4Yrs 216-08-7530 Director Usual Residence of Decedent the Menyland 10a State 10b. County 10c. City, Town or Location \*ohe 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryle Department of Heelth end Mentel Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be not the discuss Randallstown, Maryland Md. Baltimore Co. 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA 4105 Powells Run Rd. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1⊠ Never Married 2 Married 21215-0020 Specify: Black 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 9 N/Aaltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Lisa Gibson Bruce Megginson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Ipwn, State, Zip Code)
Kathleen Wilson/ FosterParent 105 Powells Run Rd. Randallstown, Md
Bruce Megginson Parent 1037 W. Lanvale St. Balto. Md, 20h Place of Disposition (Name of 20a. Method of Disposition Data 20c. Location - City or Town, State King Memorial Park 2-28-00Woodlawn, Md. 1 David 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
Tri-State Funeral Service Deander 108 west North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximete triterval Between Onset and Death Physician /Medical tmmediate Cause (Finat disease or condition resulting in death) Subarachneid 26 hours Examiner Examiner physicien end the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical Due to (or as a consequence of): Box P.O. been signed by the should be deteched Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 27 No 3 Probably 4 Unknown Hydrocephalus Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 17 Yes 2 No 1 ☐ Yes 25 No Division of Vital To the Hospital or Attending Physicien: within 24 hours eiter deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Was case referred to medicat examiner? 8 26. Place of Daath (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) THYES 2 No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 5 Pending investigation 1 SNaturat 2□ Accident 1 TYas 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48128 - /ms February 21,2000 30. Name and address of pur who completed cause of death (ttem 23a) (Type, Print) Hopkins MD, Johns Vahn Donnie 32. Regisfrer's Signature 31. Date filed (Month, Day, Year) State FEB 2 4 2000 Registrar

ORIGINAL

DHMH 16 Rev 6/95

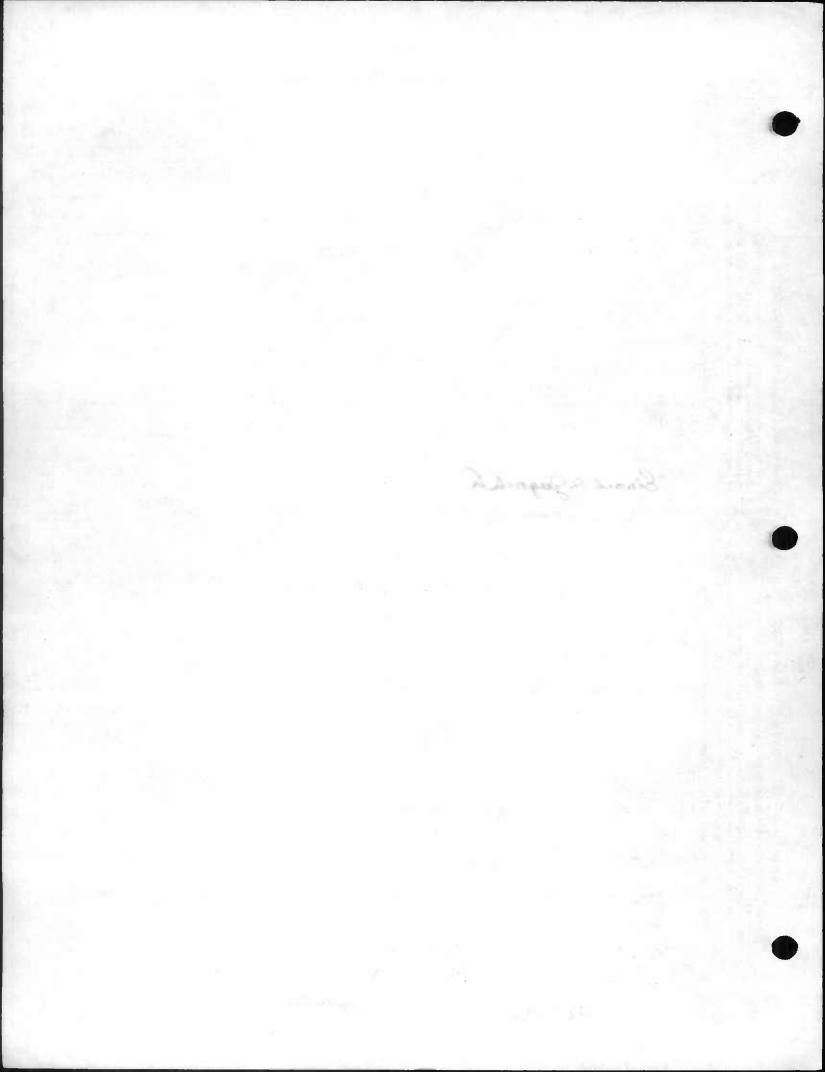


State of Maryland / Department of Health and Mental Hygiene 0 6 0 0 9

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Physician /Medical	J	udith A		enha	rdt					uary 19	Year 2000	3. Time of Death 13:46 PM
Examiner	4e Facility Nama (If not institution, go St. Agnes Ho		ber)				4b. City, To		ocation of Dea		y of Death	
Funeral Director	5. Social Security Number 6.		Age (In yrs. Ia	st birthday) Yrs.	If Unde Months	r 1 Year Days			8. Date of Bi (Month, D DEC 5.	rth ay, Year)	9. Birthp	lace (State or Foreign try) Virginia
show	Usuel Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation				1020 )	-777		0d. Inside City Limits
Office death with the Meryland ifter death with the Meryland interes 23a or 28=f show interests and precedent.	Maryland Balt:	imore			7	ato p Code	nsvi	lle		10g. Citizen of	What Coun	1 ☐ Yas 2 🖾 No
th with	5 N. Rollin	g Road				212	28				USA	
) 2 E 1	3 ☐ Widowed 4 ☒ Divorced	12. Wes Deced Armed Ford 1  Yes 2 If Yes, Give Year or Det	No No				Hispanic Ori ean, Mexical Specify:		ecity Yes or N Rican, etc.)		ce - Americ ck, White, c y: Wh:	etc.
Marylang ZIZIS-00Z0 d 2 should be filed within 72 hours siter th end Mental Hyglena. 7 is marked other than "natural; or ite traumatic event, the Medical Earnin To Be Completed by Fur	15. Decedent's Elementery/Secondery (0-12)	ducation rade completed) College (1-4	for 5+)		lent's Usu kind of wo DO NOT u		pation during mos d)	st of work	ing	16b. Kind of 8		
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d 2 should th end Men 7 is marke traumatic	19s. Informant's Neme/Reletionship	(Type, Print)		19b. Mailir	g Address	s (Street				er, City or Town	, State, Zip	Code)
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permit. Pages 1 er Department of Hea Important: If Nem 2 any Injury or other page.	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Special	ity)	ate	ro Ci	rema	tor			/23/00	Balti	more	, MD
Department of the state of the	Edward A. C	regorch		2	rema	atio Fred	on So deric	cie k R	oad Ba	MD, In		D_21228
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Physician /Medical Examiner	Immediate Cause (Fine) disease or condition resulting in deeth)	a. PUI	LMONARY								2	-3 Days
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be executed ician and burial-transit	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or Injury	D	Due to (or COHOL IN	es e conseq	uence of):		CEATII	15			1	2 Weeks 28 Years
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The law requate has been page 2 shoul										Yes 2□No	COL	mpletion of cause death?
certificata irector, pag	25. Wes case referred to medical						26. Place	e of Deat				100 2010
T digis	examiner? 1	28a. Dete of		R/Outpatien 28b. Time of Injury	1 11 11	OA Ott	her: 4 No	ursing Ho	ath (Check only one)  lome 5  Residence 6 Other (Specify)  28d. Describe how injury occurred			
	2 Accident investigetic 3 Suicide 6 Could not learnined	on 28e. Pieca o	f Injury - At hom , etc. (Specify)	ne, farm, str	M	1	Yes 2□	No		(Street and Num wn, State)	ber or Rura	l Route Number,
To the Hospital or Attentivity of A hours after deat within 24 hours after deat completely filled in by the Medical Certifical	29a. Certifier (Check only one)  Certifying P	hysician: To the be miner: On the bas end manne	is of examinetic	ledge, death on end/or im	occurred	at the ti	me, date an opinion, dea	nd place, ith occurr	and due to the ed at the time	cause(s) end m , date end place,	anner es st and due to	ated. the cause(s)
To the within To the comple	29b. Signeture and title of certifier	26	elas		29	D09	number 1990			29d. Date signe Februar		
9	30. Name and address of person who Dr. Michael E.	completed cause Pelczar	of death from 2 St. Agr	23a) (Type, I	Print)	Care	900	Cato	n Avenu	ıe Balti	more,	MD 21229
State	31. Date filed (Month, Dey, Year)	32. Reg	gistrat's Signetu		9		uls					10767

DHMH 16 Rev 6/95

JUDY MEGENHARDT

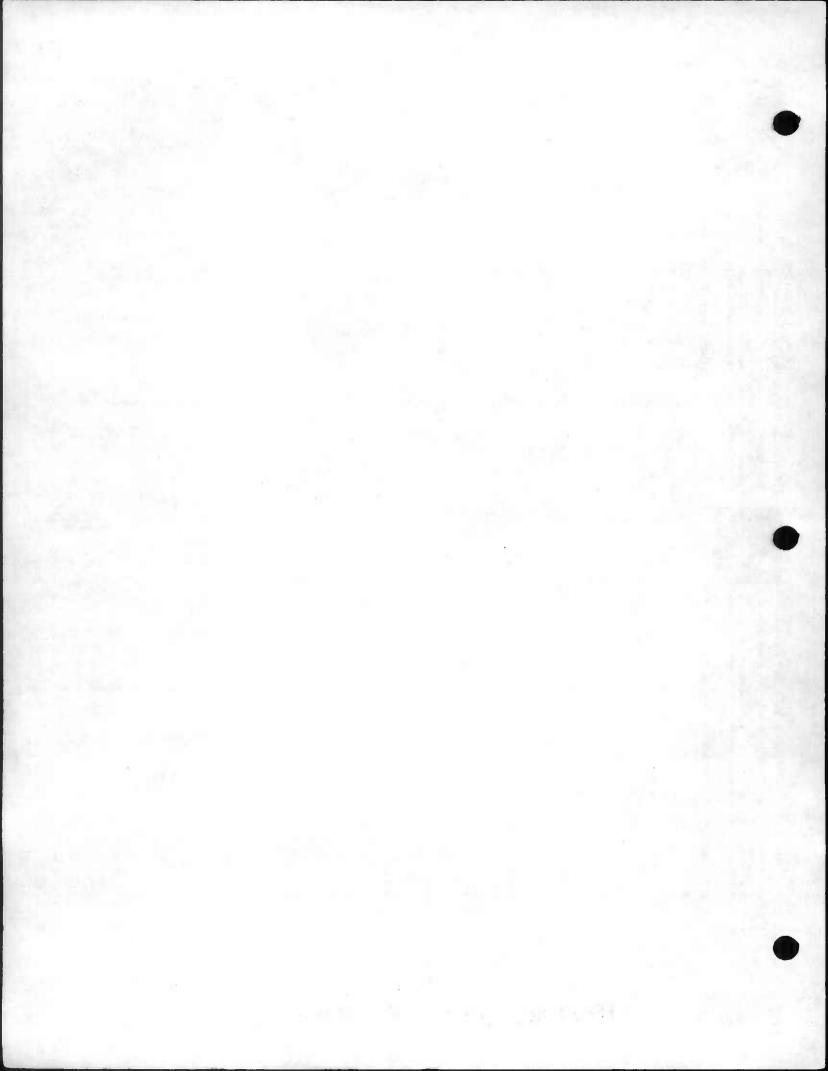


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State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 1

		Cer	tificate of D	eath	Reg. No.	3 00010
Physician	1. Decedent's Nama (First, Middle, Last)			2. Date of D	Day	3. Time of Death
/Medical	Margaret McGovern			FEB	21, 2	000 6:25 PM
Examiner	4a Facility Nama (If not institution, give street and number) Holy Cross Hospital			City, Town, or Location of Dea		of Death gomery
		(In yrs. last birthday)				0 /
Funeral Director	404-32-3009 1□ M 2F F  Usual Residence of Decedent	70 Yrs.	Months Days	Hours Min. 8. Data of B. (Month, E. DEC 1	8, 1929	9. Birthplace (Stata or Foraig Country) Kentucky
anyland ahow		10c. City, Town or Loc	cation			10d. Inside City Limits
Man Frah Hor	MD Montgomery	Kensing	ton			1 ☐ Yes 2 ☒ No
deeth with the Maryland rms 23s or 28s-f show r must be notified at neral Director	10e. Street and Number 10231 Carroll Place		101. Zip Code 20895		10g. Citizen of W	hat Country?
frer deeth v r heme 23 iner mun Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U,S. 13. W	Vas Decedent of Hisp	anic Origin? (Specify Yas or N Mexican, Puarto Rican, atc.)	lo- 14. Race	- Amarican Indian, k, Whita, atc.
by	1 Never Married 2 Married 1 Yes 2√7 No If Yes, Give ∆ Year or Dates:	1	V	Specify:	Specify.	
led within 72 hours lygiena. her than "natural", nt, no. Medical Ex- Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation	on ing most of working	16b. Kind of Bu	sinass/Industry
c 13 5	Elementary/Secondary (0-12) College (1-4or 5+)	)	kind of work done dur OO NOT use retired)	ing most or working		
C Herein	3	Home	maker	B. B.B. Ab. and a b.B. and a 4000 and 4100 and 4	Domest	
D S OUT I	17. Father's Nama (First, Middle, Last)  Frank Delong		The second	8. Mothar's Nama (First, Middl	nie Smal	
2 should be filed vent Mentel Hygie e marked other toumarde avent, to To Be Co	19a. Informant'a Name/Relationship (Type, Print)	10h Mallin	a Address (Street as	1 All1 d Number or Rural Routa Num		
semil. Pages 1 and 2 should be filed with Department of Health and Mentel Hygiena. mportanti if flam 27 is marked other than ny injury or other traumatic avent, the Note.  To Be Comp.	Stella Lebo/sister			., Baltimore,		
r oth	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Nama of natory or other place)	Data	20c. Location -	City or Town, Stata
Peges ment of the uny or o	4 Donation 5 Other (Specify)	Metro Cre	ematory, I	nc.	Baltin	nore, MD
pemil. Peges 1 and 2 s Department of Health or Important: If Itam 27 ie eny injury or other trau ands.	21. Signature of Funeral Service Louisee	22.	Nama and Address	Society of	Maryla	nd, Inc.
	Thomas Gregore  23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line			rick Rd. Ba		Approximete
certificate be executed ding physician and use as the buriel-transit VMedical Examiner	if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequ		U/	4 1	
ath certification of the same as a same	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying causa given	in Pert I. 23b. Did	d tobacco use con	tribute to the cause of death
5 50		12	1 Yes 2 No 3 Probably			
been shoul				24a. Wa	s an autopsy formed?	24b. Wara autopsy tindings available prior to completion of cause of death?
page 2				1	Yas 20 No	1 Yas 2 No
s certificate he director, page	25. Was case referred to medical		2	6. Place of Death (Check only	ona)	
Physician: this certific ral director, TO Be	examiner? 1 Yes 200 No Hospital: 1 Inpetient	2 ER/Outpatient	3□ DOA Other:	4□ Nursing Homa 5□ Ras	sidence 6 Othe	or (Specify)
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To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation	y - At homa, farm, stre			(Street and Numbown, Stata)	er or Rural Routa Number,
To the Hospital within 24 hours a To the Funeral D completely filled	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner:	my knowledge, death	occurred at the tima,	data and place, and dua to the	a cause(s) and ma	nnar as stated.
프즈트를 묶기	one) and manner state	id.			i, data and piace, a	ind dua to tha ceusa(s)
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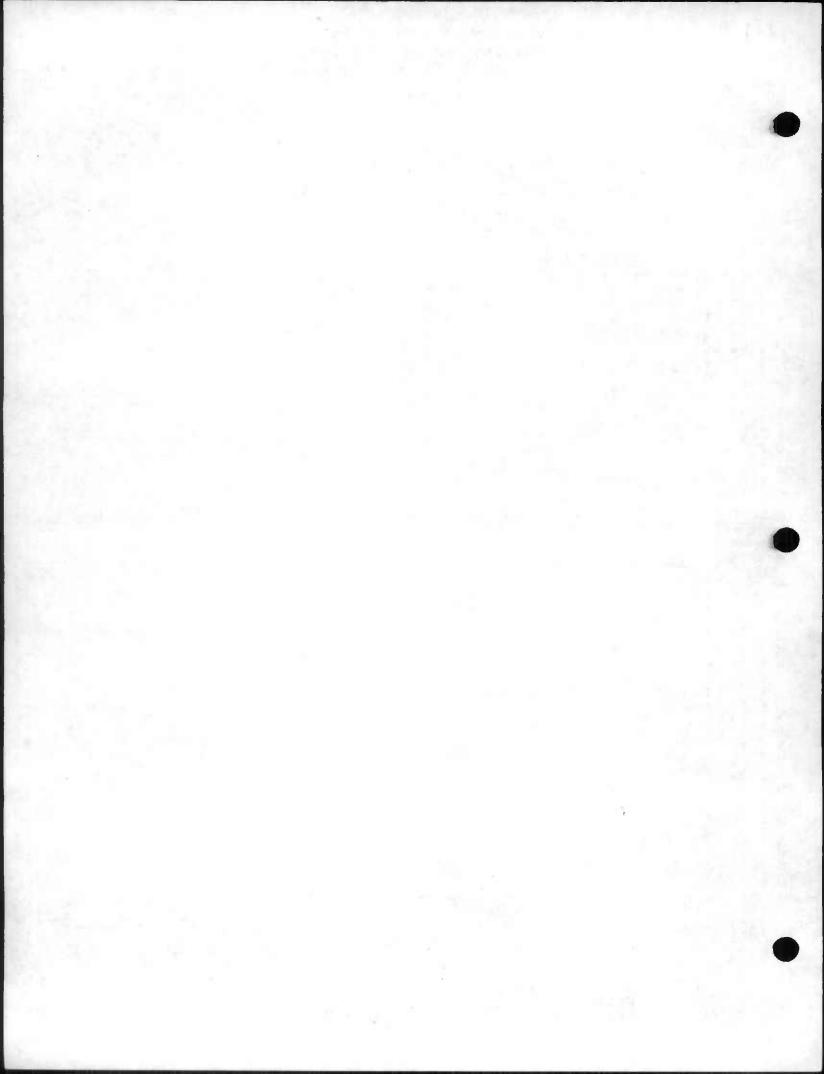


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1 Decedent's I	Name (First, Middle,	Look			Certifica	te of	Death	l a Day	Reg te of Death	j. No.		3. Time of Dea		
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		LL CENTER				Hillade	r 1 Year	PARKV		-4014	BA	LTIM			
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ž ==	10a. State	10b. County		10c. C	ity, Town	or Location						10	Od. Inside City L		
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or, or items Examiner in by Funer	3 Widow	tus Married 2□ Married red 4□ Divorced	12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or D	rces? 2 No	u,s. W II		ecedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.)  14. Raca - American Indi Black, White, etc.  Specify: WHITT					etc.			
ate de de	(	15. Decedent's Specify only highest			16a. I	Decedent's Usi 'Give kind of w	al Occup	pation during most of	working	10	5b. Kind of Bu	siness/Ind	lustry		
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His T	1 ☐ Yes 27. Manner of D	5 Pending				8e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number City or Town, State)				
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State of Maryland / Department of Health and Mental Hygiene 00 06012

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		Ann	a Eu	genia My	ers					Feb. 22	. 2000	Yeer	6:15 g
'Medical xaminer	-	4a. Facility Name (If not institu	tion, give	a street and number	ar)			4b.	City, Town, or	Location of Death	4c. County	of Death	0.17
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neral ector	-	5. Social Security Number 215–32–2161	6. S	ex 7. □ M 2 <b>X</b> F	Aga (In yrs.		thday) If Undar Months		f Undar 24 Hr Hours Mir		Year)		lece (State or Fo
	-	Usual Residence of Decedent			1								
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Director	2	Md. Baltimore Pikesville  10e. Street and Number 10f. Zip Code								1 Yes 2			
ant be n		10e. Street and Number 113 Nelso	n Ro	ad			10f. Zip (	2120	80		U.S.		itry?
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r, the Medical Exp	ole.	15. Decad (Specify only hig	ent's Ed	ucation de completed)		16a.	Decedent's Usuel	ol Occupation	on ring most of we	orkina	16b. Kind of Bu	usiness/ind	dustry
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any injury or other traumatic event, the Medical once.  To Be Completed		20a. Method of Disposition			TO I		Disposition (Name, crematory or other Ridge Ce			26,2000	20c. Location -		
any In		21. Signature of Superpal Servi	00	A				rdt Fi	neral				
	+	23a. Part1. Enter the disease, shock, or heart failure. L	or comp	olications that caus	sed the deat	h. Do n	11605 ot enter the mode	Reisi	terstow such as cardia	n Rd., O	wings M	ills,	Mol. 21
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 1 6 0 1 3

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death MILLER Month Day Year FEBRUARY 22 2000 Day VIRGIE **Physician** 0840 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDAUS TOWN BALT, MORE NORTHWEST HOSPITAL | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | Mar. 10, 1909 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 220-14-9935 90 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or litems 23a or 28a-f show 1 Yes 2 No must be notified Director Md. Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4862 Shell Bark Rd. 21117 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Marriad 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Acme Stores Cashier permit. Pages 1 and 2 should be like Department of Health and Mortal Hy Important: If Item 27 is marked other any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennie B. Agner Charles I. Navlor 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Miller - Son 12010 Tarragon Rd., Owings Mills, Md. 21117 altimore, 20b. Plece of Disposition (Name of comatery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Ramoval from State Lake View Mem. Park Feb. 25, 2000 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licansae Eckhardt Funeral Chapel 23a. Pert1. Enfer the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. Md. 21117 Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5x 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No after death.

Director: After this certifications 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1/2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Meturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier FEBRUARY 22 2000 37773 30. Nema end address of person who completed cause of death (Item 23a) (Type, Print)

C. PAVI MD, NITC, RALTO. 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** February 20, 2000 Elizabeth Rita Murphy 6.56 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 8410 Saunders Road Lutherville Baltimore If Under 24 Hrs. B. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. last birthdev) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys Months 1□M 2ÅF 87 Nov. 3, 217-40-3036 Director 1912 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland Baltimore Lutherville 1 ☐ Yes 2 ☐ No must be notified Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? or flams 23s or 8410 Saunders Road 21093 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 21215-0020 White 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Midowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4 Homemaker & Mother At Home altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Department of Health and Mental Important: If Item 27 is marked o Edward F. Kelly Susanna T. Norton Pages 1 and 2 should 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) Mrs. Jane M. McInnes (Daughter) 6428 Cloister Gate Drive Baltimore, Maryland 21212 20b. Plece of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete New Cathedral Cemetery 2/24/2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Maryland 21. Signeture of Funeral Service Ligensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road m 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final e myocardial

Due to (or as a consequenca of): diseese or condition resulting in deeth) Examiner Examiner Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as e consequenca of) requires that the death certificate be axecut Box 68760 Physician/Medical the Due to (or es e consequence of) P.O. Pert If. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown À Records, De d 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy 1 ☐ Yes 2 1 No 1 Yes 2 No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28e. Dete of fnjury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral D completely filled in edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steled. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Eventelos C. de mes 2-21-2000 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) 7801 York Road Evangelos C. Lignos, M.D.

**DHMH 16 Rev 6/95** 

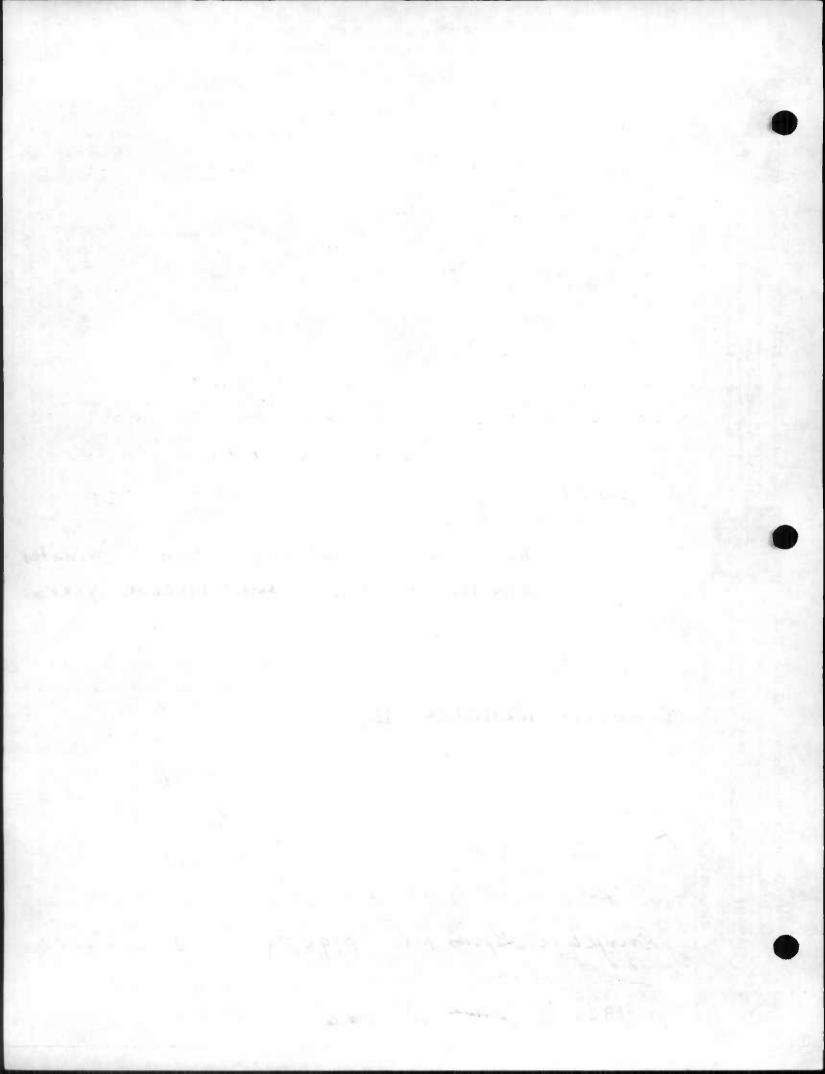
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Registrar

31. Dete filed (Month, Day, Year)

FEB 2 4 2000

32. Pyrgistrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month MCLERAN ,00 pm FEBI 18 2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 24 Hrs. 5. Social Sacurity Number If Under 1 Year 8. Date of Birth (Month, Day, Year) February 07, 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 X F Yes 219-74-7188 80 Baltimore.Md. Usual Rasidance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1602 Kingsway Road 21218 United States of America 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A Home Maker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Lee Cole Frances Roberts 19a. Informent's Neme/Reletionship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3533 East Northern Parkway Apt.C 3 Baltimore, Md. 21206 Mrs. Jeannette McL. Seiple(nee McLeran) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge Cemetery 02/22/2000 Baltimore, Maryland 21. Signetura of Funeral Service Licenses Jeffrey L. Gair 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 ave sa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 72hou Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): thet initieted events rasulting in death) Lest Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Neturel 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner attending physician and for use as the burial-trans Box 68760. certificate be P.O. |

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/Medical

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Baltimore, Maryland 21215-0020

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Examiner Physician/Medical þ Completed Be Medical Certification: To

signed by it cate has been significant categories categor certificate Attending Physician: this After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun.

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**DHMH 16 Rev 6/95** 

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29e. Cartifiar

29b. Signeture end title of/certifian

29c. License numbe

29d. Date signed (Month, Day, Year)

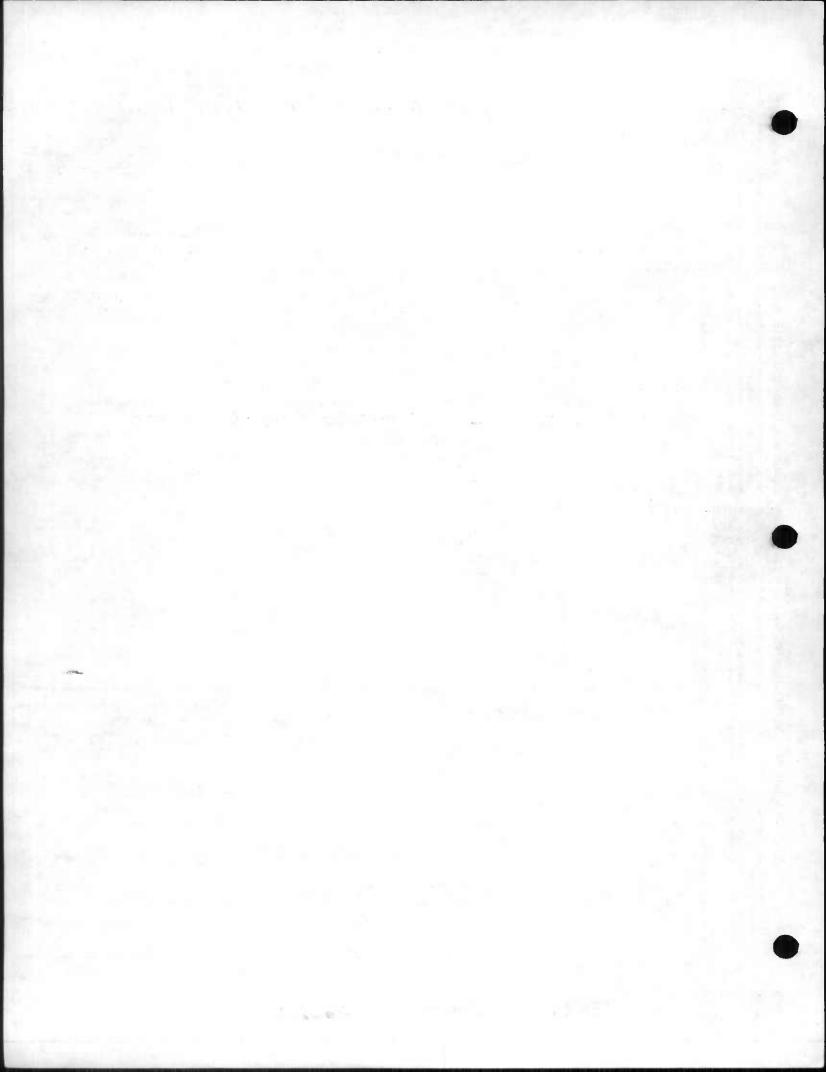
use of death (Item 23a) (Type, Print)

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31. Dete filed (Month, Dey, Year) FEB 2 32. Registrar's Signeture

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 12:15AM John David Hillis February 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 10 M 20 F Months Hours 219-03-0236 79 July 3, 1920 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Freeland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21053 1221 Walker Rd USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemist Printing 17 Father's Name /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumame) Laura Parker Frank Norman Hillis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ellen M. Hillis/ Wife 1221 Walker Rd. Freeland, MD. 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Entonoment Dulaney Valley Mem. Gdns. Timonium.MD. 21. Signature of Fungfal Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 aur 23a. Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL FAILURE disease or condition resulting in death) CHOLESTEROL EMBOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SUBJECTE BATERIAL ENDOGARDITIS 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No CAROLARY ATTERY DISEASE 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? MULTI-INFARET PETENTIA 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1□ Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA

**Physician** /Medical Examine

**Physician** 

/Medical

Examiner

MD.

**Funeral** 

Director

r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or then any injury or other traumatic avant, the Medical Engine

Baitimore, Maryland 21215-0020

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Examiner physician and the burial-transit Certification: To To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical

Physician/Medical by Completed Be

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Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Morith, Day, Year)

29b. Signature and file of cartif

27. Menner of Death

1 2 Naturai

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier (Check only one)

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1) 7263

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year) 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

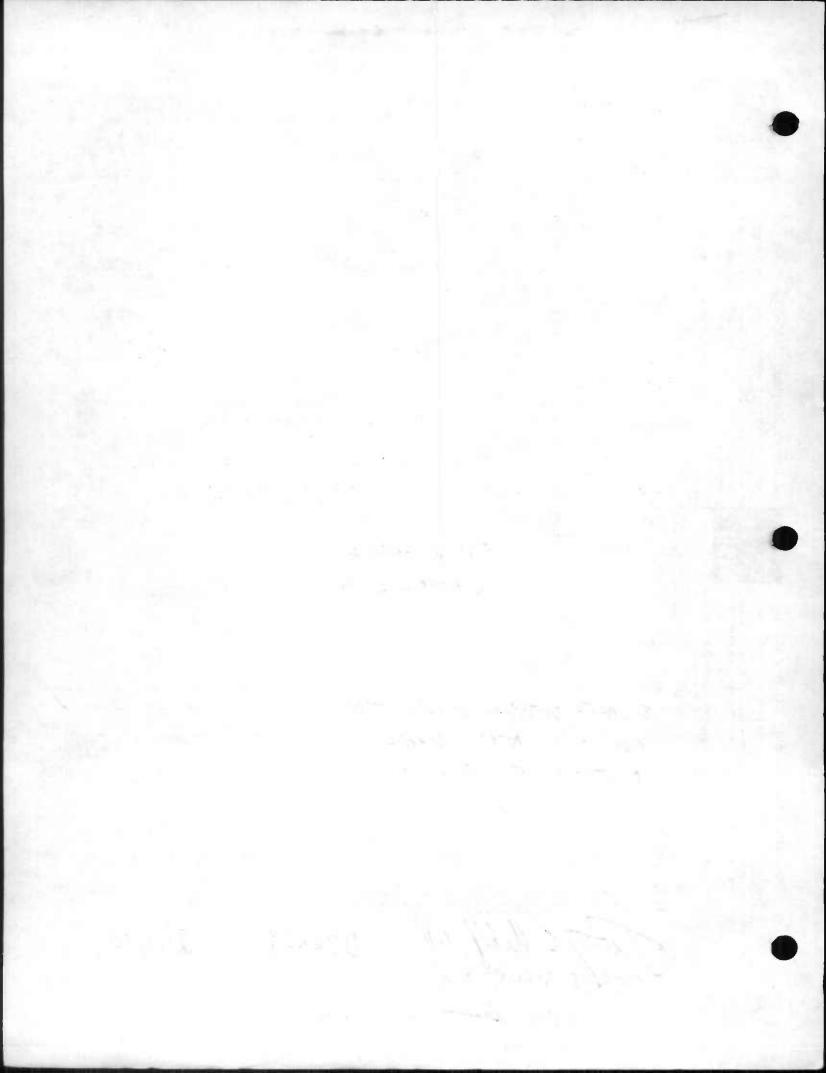
death (Item 23a) (Type, Print) HERLIA TIMOTHY

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

books



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** 750 AM FEB 22 FB ORAH 1CGOWAN 2000 \* /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE LERCY HOSPITAL If Undar 24 Hrs. If Undar 1 Yaar Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 219-70-0413 1 M 2 F Months Days Hours Yrs. **Director** Usual Rasidance of Decedant the Marylenc 10b, Count 10a. Stata 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Modical Examiner must be notified at 1 Yas 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? WITH MLEAF COURT 1200 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yes ≥ Ø No If Yes, Give Yaar or Dates: 14. Race - Amarican Indian, Black, Whita, atc. 12 Navar Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: BLACK Specify: py 3 ☐ Widowad 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Dependent of Health and Mentel Hygiene. Important: if Itam 27 Is marked other than "natural", any fujury or other treumatic event, its Medical Expense. Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 10 +HGRADE TTENDANT BROADWAY DERVICES 17. Father's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Be 0 ARRIE UIMMIE 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Ralatlonship (Type, Print) AVENUE, BALTIHORE, MD. 21205

Data 20c. Location - City or Town, Stete CAROLYN BRAXTON SISTER) 1624 ASHLAND Baltimore. 20b. Place of Disposition (Nama of cemetary, cramatory pr other place) 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 02-25-00 CATONVILLE, MD. WESTERNSTAR 21. Signatura of Funaral Sarvice Licensaa

22. Nama and Addrass of Facility

23. Nama and Addrass of Facility

24. Nama and Addrass of Facility

30. SEPH H. BROWN JR. F-UNERAL Home

21. 40 N. FULTON AVE., BALTIHORE, Mp. 21217

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

Approximate BROWN JR. FUNERAL HOME **Physician** BREAST (ANCER /Medical Immediata Causa (Fina ic e YPARS disease or condition rasulting in deeth) **Examiner** Examiner the ettending physician end thed for use es the bunel-transit certificate be executed Sequantially list conditions, if any, laeding to immadiate causa. Enter Underlying Causa (Disease or Injury that Initiated avants rasulting In death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other eignificant conditions contributing to death but not rasulting in the undarlying causa given in Part I. signed by the 1 Yes 2 No 3 Probably Minknown Records. þ 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of causa of death? hes 1 ☐ Yas 2 ☐ No Division of Vitai I certificate funeral director, Be 25. Was casa rafarrad to medical axaminar? 26. Plece of Death (Chack only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Department 2 ER/Outpatlant 3 DOA this 27. Manner of Death 28b. Tima of 28c. fnjury at Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) i or Attending F safter deeth. f Director: After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 ☐ Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 - Homicida Hospital 24 hours 12 certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifiar Medical (Check only one) To the F within 2 To the F 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier

State Registrar

SOS EPM 31. Data filed (Month, Day, Yaar)

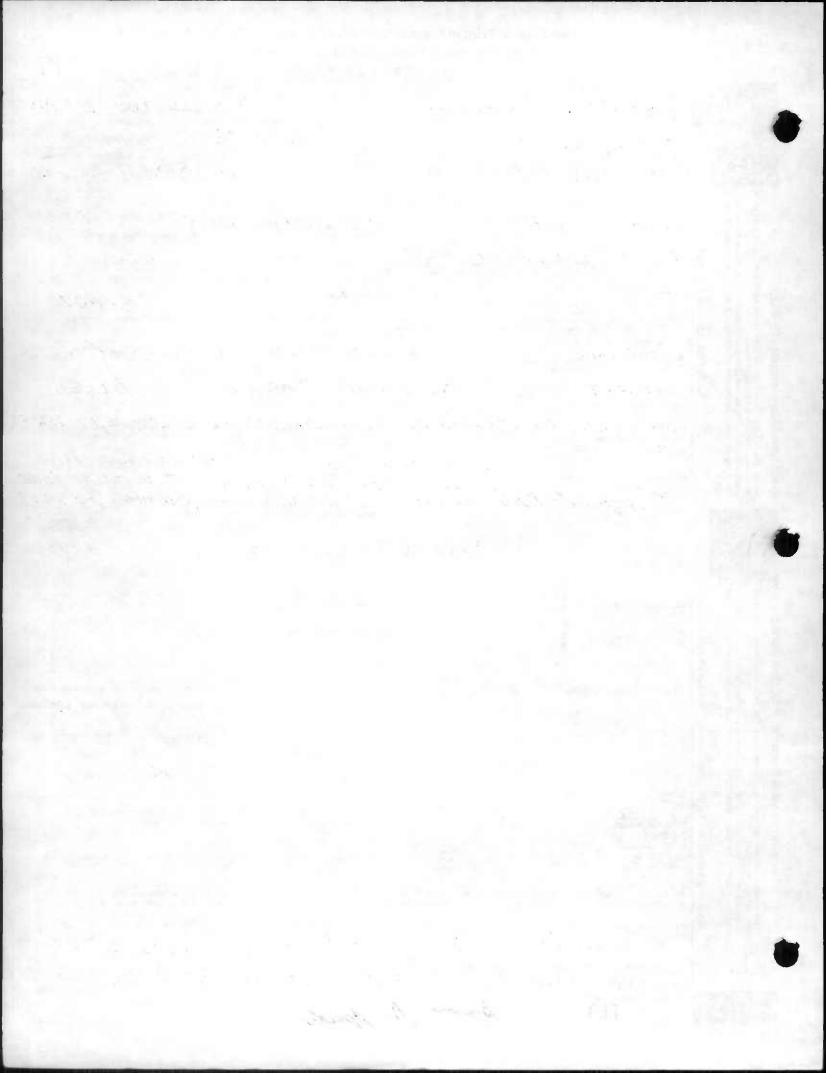
32. Registrar's Signetura

**DHMH 16 Rev 6/95** 

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30. Nama and addrass of pursuin who completed causa of death (Item 23e) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 22:00 PM 21, FEBRUARY 2000 Mary Helen Mason /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Agnes Healthcare Baltimore N/A If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 2以F Yrs. Director 112-10-5949 97 Oct. 16, 1902 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylei Deperturent of Health and Mentel Hygiene. Important: If fem 27 is marked other than \*natural; or fema 23 a or 28e-f ehow any Injury or other traumatic event, its \*edical Example must be notified any Injury or other traumatic event, its \*edical Example must be notified. Maryland Baltimore 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Sfreef end Number 10f. Zip Code 10g. Citizen of What Country? 1220 Leeds Terrace 21227 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: White 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dept. of Defense 12 0 Civil Servent 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Engelhardt Caroline Schoepf 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary H. Powdermaker/ Daughter 1220 Leeds Terrace, Baltimore, Maryland 21227 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 2-23-2000 Baltimore, Maryland of Funeral Service Lid 22. Name end Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician HRMORRHAGE /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) MASSIVE INTRA GRANIAL UNKROWN Examiner Due to (or es e consequence of) **buriel-transit** Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lesf and Due to (or es e consequence of) physician s the buriel P.O. Box 68760. Physician/Medical Due to (or es e consequence of): USB BS Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24a. Wes en eutopsy 24b. Were eutopsy findings peeu evelleble prior to completion of cause of deeth? has page 2 certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? Be 28. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred i or Attending F efter death. Director: After After 5 Pending investigation 12 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could nof be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 2 4 - Homicide To the Hospital
within 24 hours a
To the Funeral C edical 29a. Certifier 🗷 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Dey, Year) FEB 2 4 2000

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30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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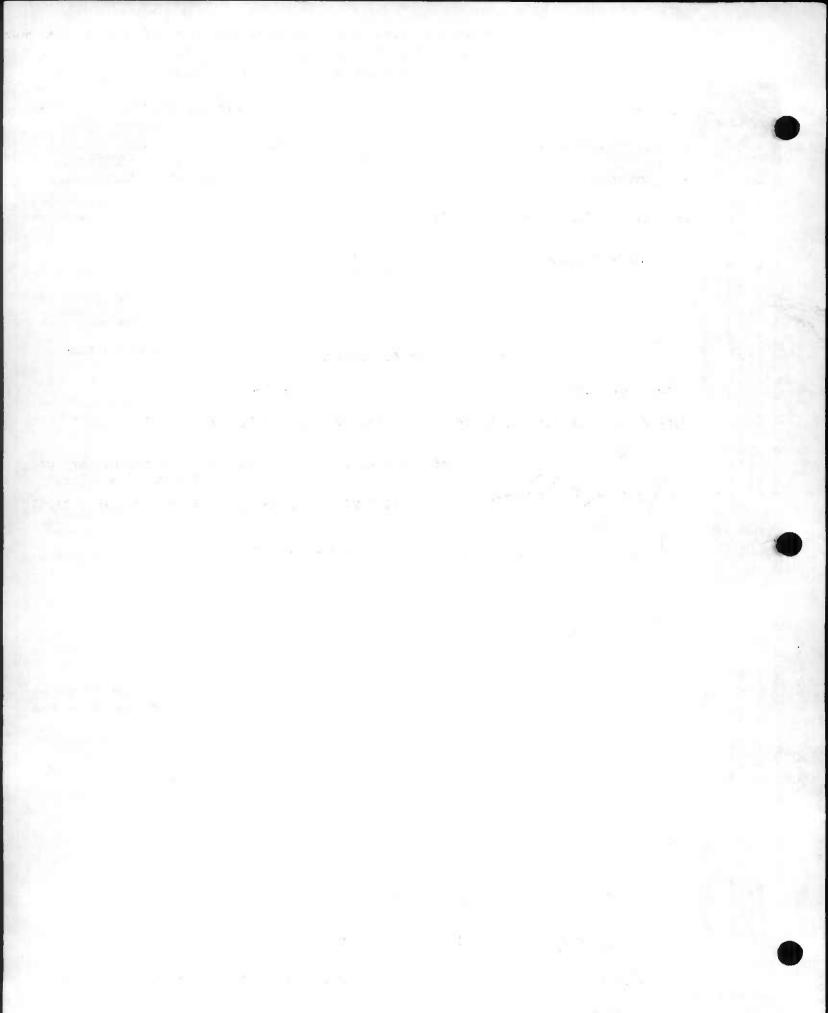
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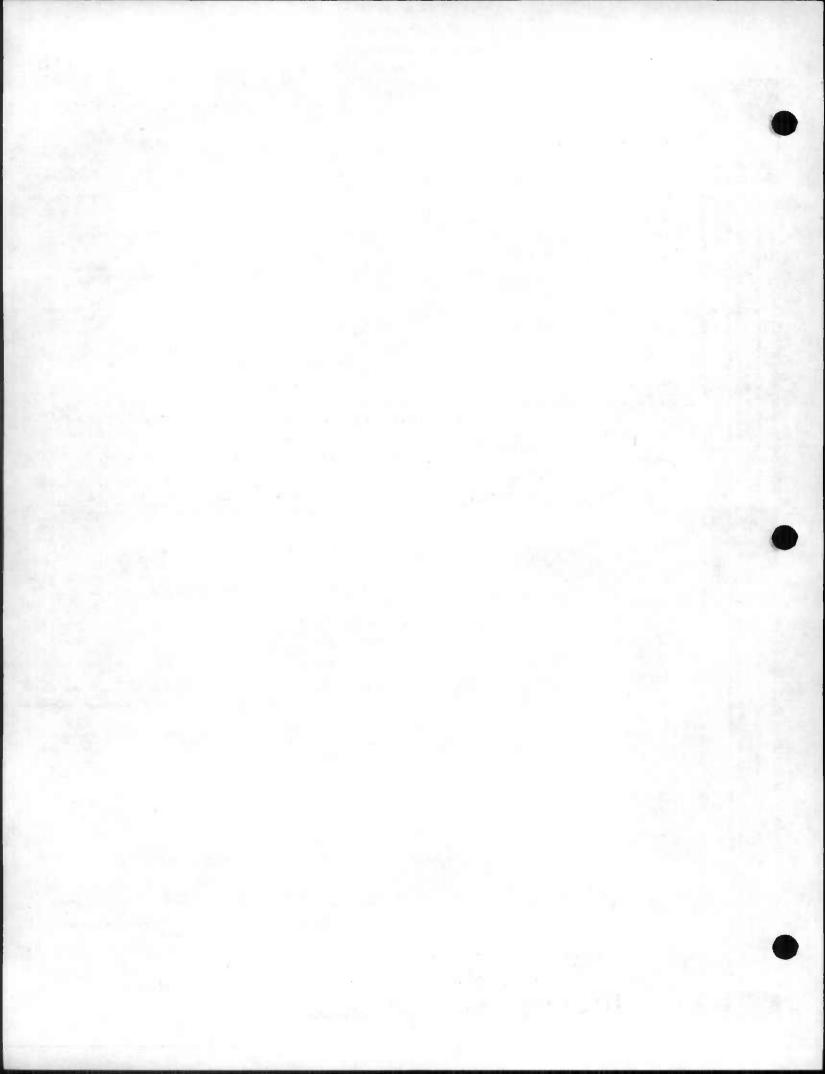
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MUSPITAL



Piease Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month **Physician** Charles Baum Mitten, Sr. February 22, 2000 5:45 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1801 Sutton Avenue Relay Baltimore If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Min. Hours 15 M 20 F Months **Director** 83 221-05-6959 Delaware Usual Residence of Decedent the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland N/A Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23s or 1638 Forest Hill Avenue 21230 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? hours after 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: White "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mernal Hygient important: if flam 27 is marked other that any Injury or other traumatic avant, the page. 12 0 Electronic Technician Westinghouse 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Hall Mary Baum 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma F. Mitten/ Wife 1638 Forest Hill Avenue, Baltimore, Maryland 21230 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 2-25-2000 Baltimore, Maryland Loudon Park Cemetery of Funeral Service Licell 21 Signatur 22. Name end Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final ARDIO PTYOPHTHE disease or condition resulting in deeth) Examiner SEATSIS PONHIPA physician and s the burial-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) HTHEROSCLEROK Box 68760 Physician/Medical Due to (or as a consequence of). P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 thinknow Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Deen 1 Yes 22 No 1 Yes 2 No certificate Division of Vital Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury ef Work? To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No investigation 2 Accident 8 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) my know better and address of person who completes cause of death (Item 23a) (Type, Print) Anil Fatterpacker, M.D. 720-D Maiden Choice Lane Catonsville, Maryland 21228 32. Registrer's Signature State Registrar

**ORIGINAL** 



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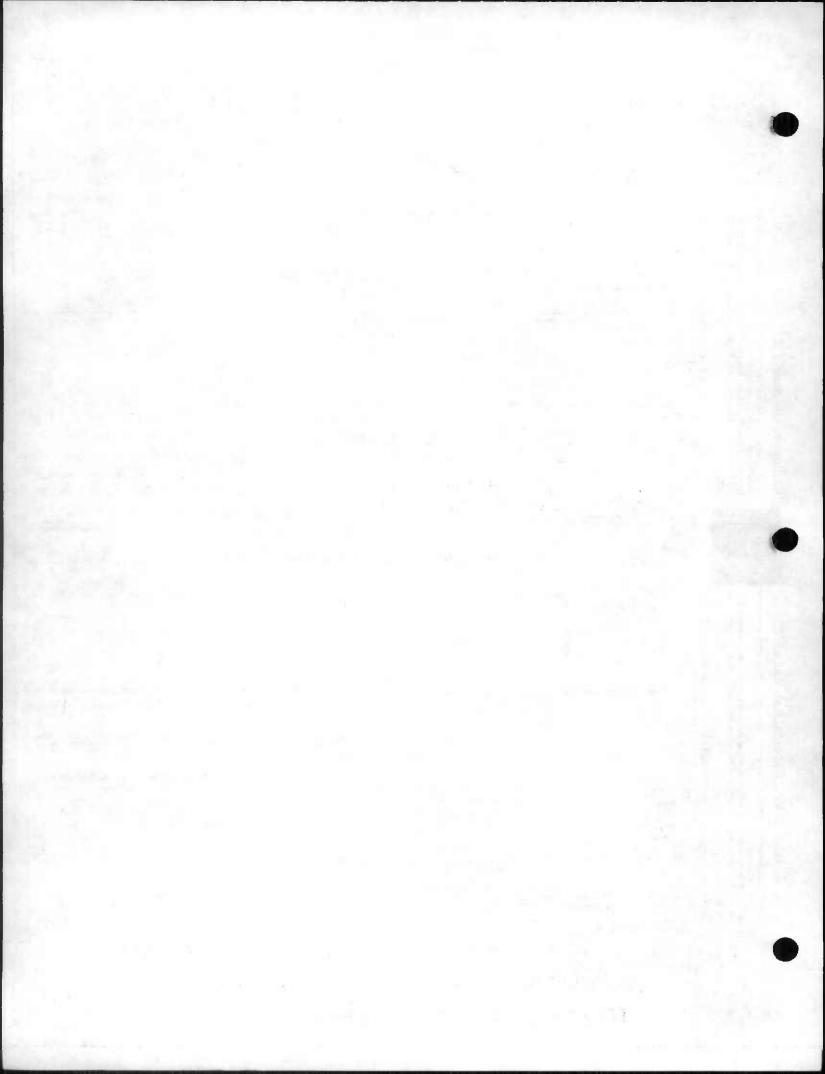
State of Maryland / Department of Health and Mental Hygiene

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6	30.	Name and addr	ess of person who	completed cause	. 1	n 23a) (Type,	Print)	C.M.E?	3.2			
State	31.	Data filed (Mon	th, Day, Year)		gistrar's Signa	iture	Pe	nn Street,	Baltin	ore, Ma	arylar	M 21201

Registrar

FEB 2 4 2000 Deneva



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\bigcap$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20, 2000 John E Murgatroyd Jr. February 3:55pm. 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 4008 Putty Hill Avenue Baltimore County Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer)

9. Birthplace (State or Foreign Country)

March 27,1918Baltimore, Maryland 5. Social Security Number 7. Age (In yrs. lest birthdey) 10 M 20 F Yrs 218 18 5890 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Putty Hill Avenue 21236 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: W ∏ 1 Never Married 2 XMarried 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Transportation Supervisor Alliance Rehabilitation Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Elmer Murgatroyd Sr Elizabeth V Hess 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Jane Murgatroyd (wife) 4008 Putty Hill Avenue Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremetion 3 Removal from Stete Gardens of Faith Cem. February 23,2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensea 22. Name and Address of Facility
Lassahn Funeral Home 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236 Approximate erval Between Onset and Death Immediate Ceuse (Final Months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannes-of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier

Box 68760. P.O. Records, Division of Vital

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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Medical Certification:

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

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Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

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State Registrar Halle 4920 32. Registrar's Signature Campbell Whole White March, Mrs 21236

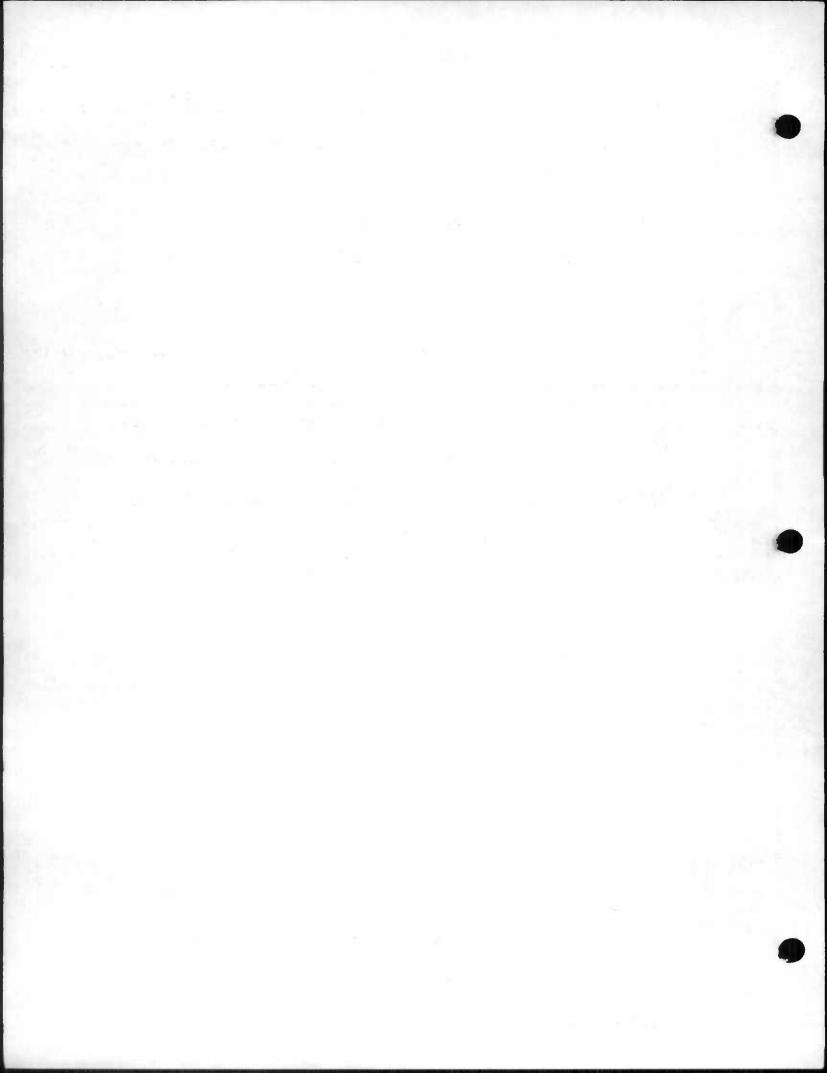
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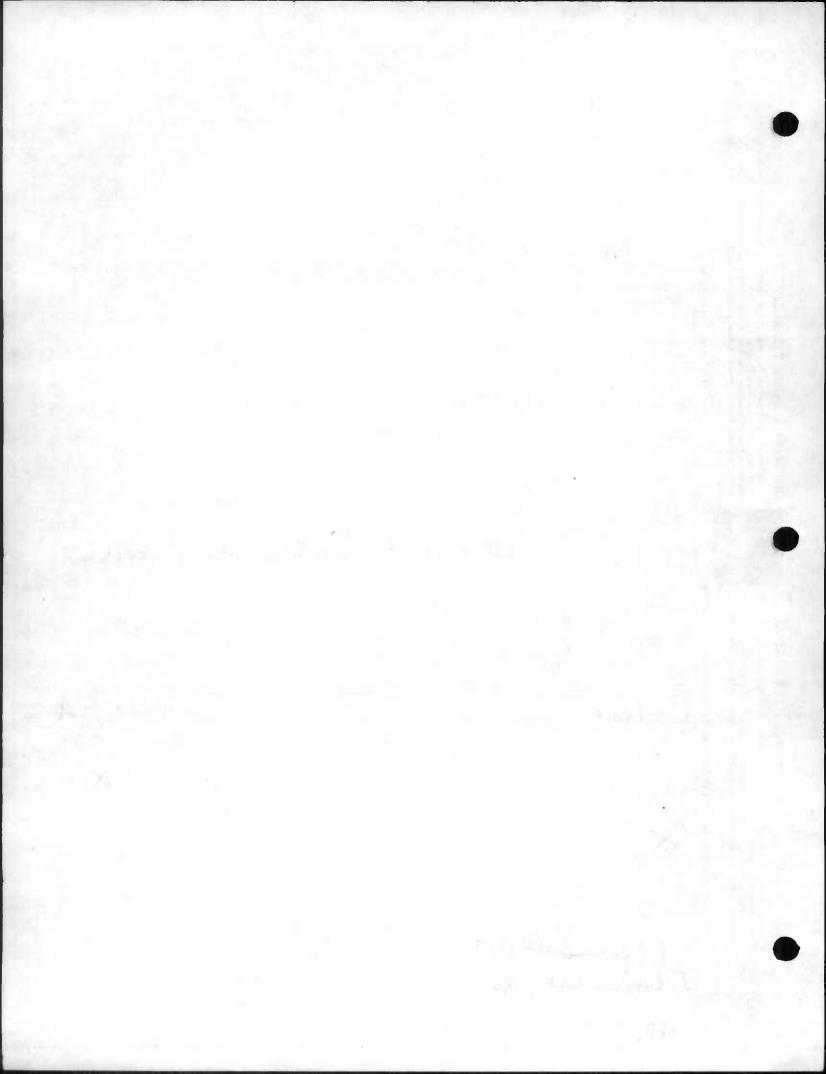
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30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)



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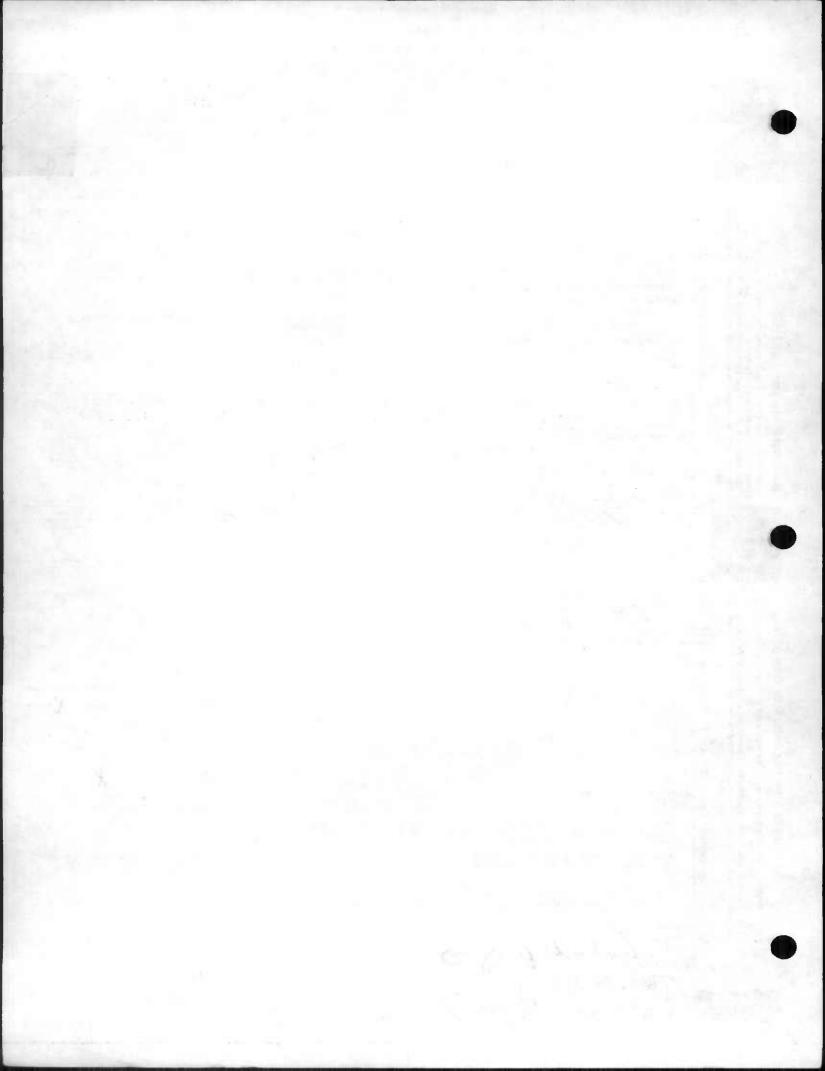
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Of Vita Physician: this certific	2	XIX Yes 2□ No			2 ER/Outpatie	nt 3□ DOA	Other: 4 Nursi	ing Home 5XXRe	sidence 8 DOth	ner (Specify)	
Division of Vital Re to a transling Physician: The to after death.  Director: After this certificate he is by the funeral director, page	Certification:	E ( ) 100100111	stigation	e ot Injury onth, Day Yea	28b. Tima o Injury	W	uryat ork? □Yes 2□No		e how injury occur	rred	
DIVISION AND STREET OF AND STR	Certifi	3 Suicide 6 Cou	mined 28e. Pla	ce of Injury - i iding, atc. (Sp	At homa, tarm, si pecify)	treet, factory, office	9	28f. Location City or 7	(Street and Numl own, Stete)	ber or Rural Rout	e Number,
	ope		ring Physician: To the si Examiner: On the end me								ause(s)
Tor	2	29b. Signafulayand title of certi	Lislay	40			o.C.M.E	•	29d. Data signe FEBRUAR	id (Month, Day, ) Y 23, 20	(ear) )00
VX/	1	J- LARON	on who completed ca				ltimore	, Marylar	nd 21201		
State Registra		31. Data filed (Month, Day, Yea	heres	Registrar's S	gnature In	a Kat					



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State of Maryland / Department of Health and Mental Hygiene

ysician	ITEMS #23 PART I,  1. Decedent's Name (First, Middle, Las	st)					2. Dete of D Month	eath		a of Death
/ledical	Robin Ann Fo		у				FEBR			54
aminer	4a Facility Name (If not institution, give HOWARD COUNTY GE					4b. City, Town, or COLUMBIA		th 4c. County		
eral	5. Social Security Number 6. S		(In yrs. last birt		der 1 Year	If Under 24 Hrs.	8. Date of B		9. Birthplace (Ste	te or Foreig
ctor	217-06-6419 1 Usuel Residence of Decedent	□ M 2⊠F	31	frs. Month	s Days	Hours Min.	April	24,196	Country)	DC
in the	10a. State 10b. County		IOc. City, Town	or Location						e City Limits
Director	Maryland Howar	d i	Lau		Zip Code		-	10g. Citizen of W		
3 0	8283 Mary Lee	Tana		101. 2		723				
Sher must	11. Marital Status	12. Wes Decedent Ev	er in U.S.	13. Wes Dec			pecify Yes or N		ed State	
edical Examiner must be notified at letted by Funeral Director		Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1000	ecify Cub 2☐No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Specify:	k, White, etc.	
			168	Decedent's Us	suel Occur	nation		16b, Kind of Bu	White	
t, the Medical	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)		(Give kind of I life. DO NOT	work done use retire	during most of word)	rking			
J. C.		1	n	omemal	ker	18. Mother's Nar	me (First, Middle	Own H		
any injury or other treumatic evant, price.  To Be C.							h E. H			
To	19a. Informant's Name/Relationship (7	(vpe. Print)	19h	Meiling Addre	ss (Street	and Number or Ru			Stete, Zip Code)	
Tre.	Marsha Gorelik								21045	
othe	20a. Method of Disposition		20b. Place of	Disposition (A	lame of	1	Date	20c. Location -	City or Town, Stete	)
7 9	1 Burial 2 Fremetion 3 4 Donation 5 Other (Specify	Removel from State				ematory	2/24	Arlin	ngton, V	7 A
5	21. Signeture of Fuperal Service Licen		//			ess of Facility			uneral	
ian ical ner	23a. Part1. Enter the disease, or companies. List only of firm ediete Cause (Final disease or condition resulting in death)	a. PROMI	ETHAZIN	E INTO	XICAT		c or respiratory	arrest,	Approxi Intervel Onset e	nete Between nd Deeth
		De	ue to (or es a c	onsequence o	t):				1	
the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	ue to (or as e o	onsequence o	f):					Η.
-	resulting in death) Last	C	ue to (or as a c	onsequence o	Ŋ:					
eteched for use as Physician/Med		0.							ı	
ched S	Part II. Other significant conditions co	ontributing to death but	not resulting In	the underlying	cause gi	ven in Part I.		.,,	ntribute to the cau	10
2							1	Yes 2 No	3 Probably	Minkno
page 2 should							24a. Wa	s an autopsy omed?	24b. Were autop available pr completion of death?	sy findings ior to of cause
8 E	Marie a further						1/4	Yes 2□No	1 Yes	2□ No
0 45	25. Wes case referred to medical					26. Plece of Dea	ath (Check only	one)	1	
d or. p	examiner? 1 Yes 2 No	Hospitaf: 1 ☐ Inpatient	2 ER/Out	patient 3🖾	DOA OU	her: 4 Nursing H	lome 5□ Res	sidence 6 Othe	er (Specity)	
director.	07 14 4 D 1	28a. Date of Injury (Month, Day )	(ear) 28b. T	ime of P	28c. Inju Wo	ry et rk?	28d. Describe	how injury occurr	red	
director.	27. Manner of Death					Yes 2 No	UNKNOW	N		
director.	1 Netural 5 Pending investigation	2-21-200	- At home far	m, street, fect	ory, office		City or To	own, Stete) 82	er or Rural Route I 83 MARY I	Vumber, LEE L
director.	1 ☐ Netural 5 ☐ Pending	29. Place of Injury building, etc.	(Specify) SIDENCE				LAIREL.			
director.	1 Netural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 8 Could not be determined	29. Place of Injury building, etc.	my knowledge, kamination end	death occurre	ed at the ti			cause(s) and me		se(s)
director.	1 Netural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 8 Could not be determined	2-21-200 28e. Place of Injury building, etc. (RES) valcian: To the best of place: On the basis of each	my knowledge, kamination end	death occurre	ed at the ti		, end due to the	cause(s) and me , date end plece, e		
pletely filled in by the funeral director, edical Certification: To Be	1 Netural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  5 Pending investigation 8 Could not be determined	2-21-200 28e. Place of Injury building, etc. (RES) valcian: To the best of place: On the basis of each	my knowledge, kamination end	death occurre	ed at the ti	opinion, death occu	, end due to the	cause(s) and me , date end plece, e	end due to the cau-	ır)
director.	1 Netural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  5 Pending investigation 8 Could not be determined	2-21-200 280 Place of Injury building, etc. RES ysician: To the best of r inner: On the basis of exand manner state	my knowledge, kamination end	death occurre Vor investigati	ed at the ti on, in my o	opinion, death occu se number M.E	o, end due to the irred at the time	e cause(s) and me , date end plece, e 29d. Date signed FEBRUARY	end due to the cau-	0



### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vasi **Physician** Edwin Francis Nitsche February 20 2000 9:10 A.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of North Arundel Glen Burnie Anne Arundel If Under 24 Hrs. If Under 1 Yeer Months Deys 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1.KJ M 2□ F 215 05 5875 Yes 82 Director Oct. 21, 1917 | Pennsylvania Usual Rasidence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number Mariner Health of N. A. 10g. Citizen of What Country? 10f Zin Code 313 Hospital Drive 21061 U.S. death \ Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: ₩. ₩. II 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) . Peges 1 and 2 should be filed wi tment of Heelth and Mental Hygien tant: If item 27 Ia marked other the lury or other traumatic event, the 10th Carpenter U.S. Naval Academy 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Frank Nitsche Minnie Nitsche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Marjorie Nitsche Wife 201 Grove Park Road Baltimore, Maryland 21225 20b. Ptece of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Department of Important: If eny Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park2/23/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22, Name end Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerouski 23a/ Pert1. Entar tha disease shock, or heart feiture. opplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, by one cause on each line. Approximete Intervel Between Onset and Death **Physician** ALZHEIMER TYPE Immediata Causa (Final disease or condition resulting in death) /Medical **Examiner** Dua to (or as a consequence of) Examine physician and the burial-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24a. Wes an autopsy performed? has page 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) 1 Yes 20 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 1 Maturat 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Attanding 5 Pending investigation n 24 hours after deeth. Funerel Director: Afti bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide 8 Hospital edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi (Check only one) iner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certific 29d. Date signed (Month, Day, Year) 30. Name end eddrass of person who completed cause of death (Item 23a) (Type, Print) RAIN TOWSRS KICHARD ISHER

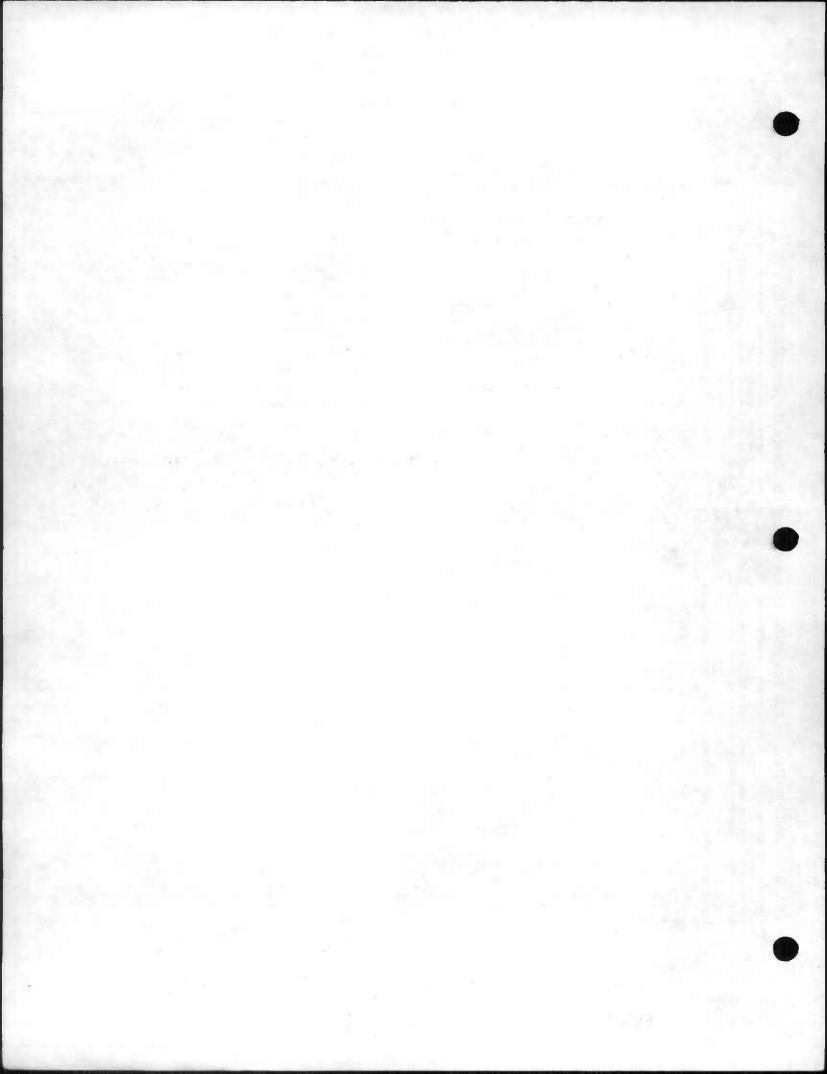
State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year)

FEB 2 4 2000

32. Registrar's Signature



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Examiner	And Process	ility Name (/	Il not institution	ion, <i>give s</i>	street and nu	umber)			4	lb. City, Town,	or Location of Dec		County o	f Death	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth ROBL Dey 3, 2000 6:39 Au JUSEPH FEBRUARS 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Randalloco...

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
May 4, 1909 Baltimore Northwest Hospital 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MD 90 216-01-0272 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County MD Baltimore Reisterstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21136 511 Glen Granite Rd. 12. Wes Decedent Ever in U,S. Armed Forces?

1 [X]Yes 2 □ No if Yès, Give Year or Dates: WW I ] Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White WWII 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Accountant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Mary M. Ritterich Joseph Robl 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Glen Granite Rd., Reisterstown, MD 21136 Wife Rose A. Robl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 2/25/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Holy Redeemer Cemetery 21 Signature of Funeral Service Linenses 22. Name end Address of Facility 11824 Reisterstown Rd Reisterstown, MD Eline Funeral Home Lone Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final EPSUS disease or condition resulting in death) Coli WJ Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Bleed 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Auguna 1□ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Maprier of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1º ☐ Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

the death certificate be executed physician end is the bunal-trans P.O. Box 68760. Division of Vital Records. this certificate or Attending Physicien: after death. Director: After this certific

98 signed by the director To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

Hydene. yther than "natural", or itema 23e or 28a-f show ent, I'm Medical Examiner mail be inclined at

permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If them 27 is marked other than matural, or item eny injury or other traumatic event, the Mental Once.

**Physician** /Medical

Examiner

Examiner

Physician/Medical

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2

Certification:

Medicai

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

with the Maryland

death

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 4 2000

29b. Signeture and title of pertifier

IMPERIOR mo 32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

mo

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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#### Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year John Martin Rehberger, Sr. February 22 2000 4:06AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Multi Medical Nursing Home Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys 1⊠M 2□F Hours 218-32-1341 83 June 21 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. Baltimore Towson 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 York Rd. 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +10 Medical Doctor Ear, Nose & Throat 17. Fether's Name (First, Middle, Last) 18 Mother's Neme (First, Middle, Meiden Surname) Dr. George Rehberger Ellen Martin 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy Sohn/ Sister 8 Ridgefield Rd. Lutherville, MD. 21093 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1⊠ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) St. John Long Green Cem. 12-25-00 Long Green, MD. 21. Signeture of Funeral Service Liga 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 Approximete Interval Between Onset and Death that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, tmmediete Cause (Final Years disease or condition resulting in death) years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? eti Nephropathy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 6 Could not be

Examiner physician and s the buriel-transit Box 68760 Physician/Medical signed by the aid to be detached for P.O. Records. by Completed has certificate Division of Vital 8 2 ş funeral To the Hospital or Attending Pi within 24 hours efter death. To the Funeral Director: After the complataly filled in by the funeral Certification: Aftar edical

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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r than "netural", or items 23s or 28s-f ehor the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hyglena. Important: if item 27 is marked other than "natheny injury or other traumatic event, the Madda ones.

**Physician** /Medical

Examiner

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72 hours after

Maryland 21215-0020

altimore.

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1.23Neturel 2 Accident 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 13 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

Me leave

29d. Date signed (Month, Day, Year)

Feb 22 2000

Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

29b. Signature and title.of editing

ne and address of person who completed cause of death (Item 23a) (Type, Print)

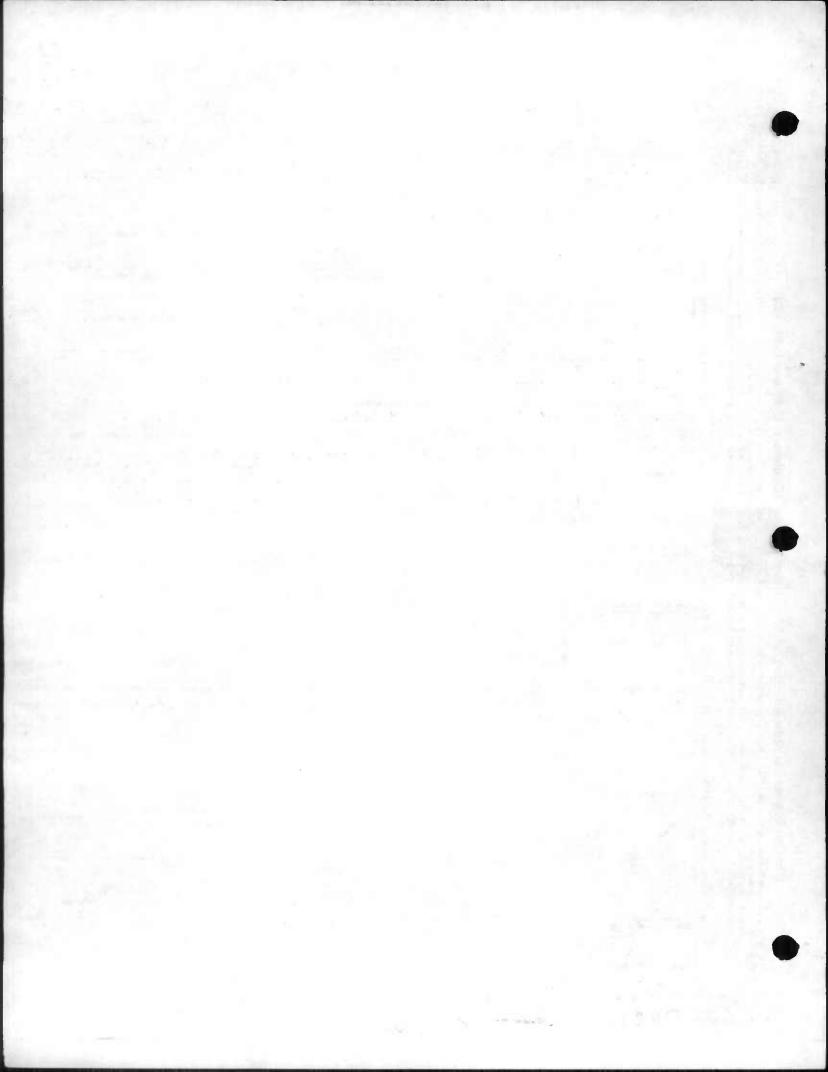
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32. Registrer's Signature doorte

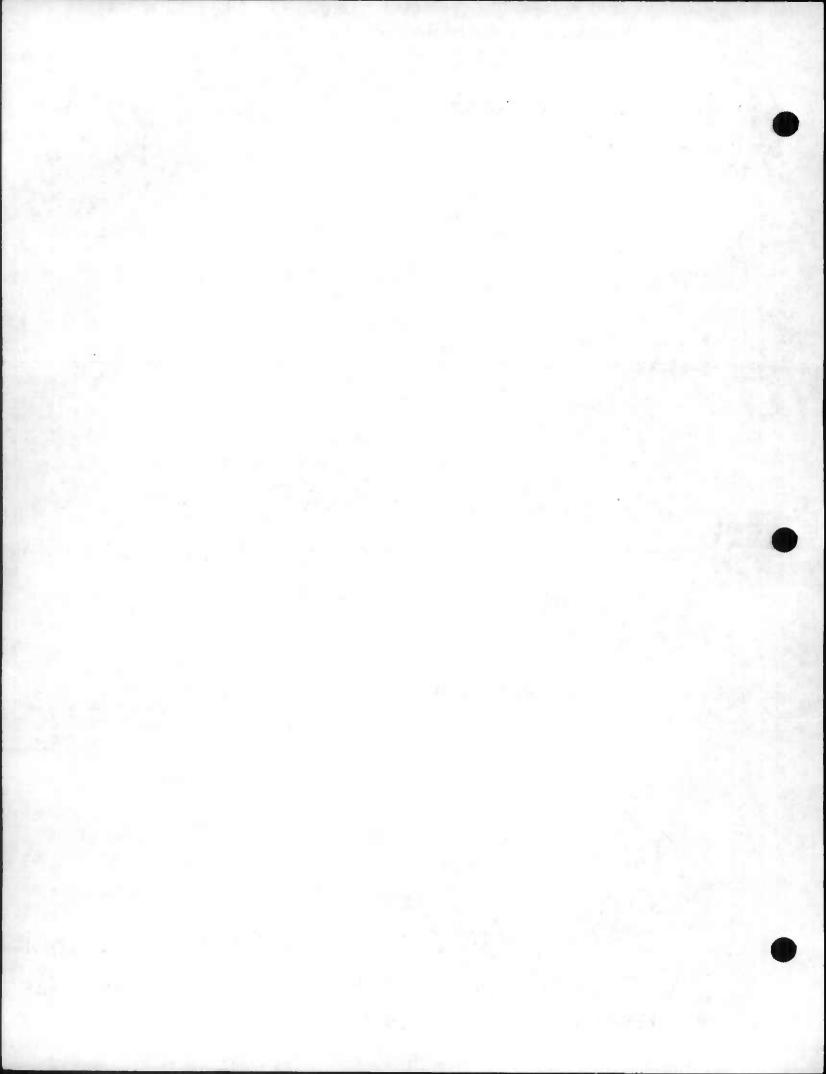
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Last		ertificate of	Death	2. Dete of Dear		3. Time of Death
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220-30-8237	6. Sex 1 ☐ M 2 <b>X</b> F	Age (In yrs. last birthdi 64 Yrs	Months Deys		8. Dete of Birth (Month, Dey November	<sup>Year)</sup> 2,1935	Birthplace (State or Foreig Country)     NY
Usual Residence of Decedent  10a, Stete 10b, County		10c. City, Town or	Location				10d. Inside City Limits
MD Howard			land		4 5		1 ☐ Yes 2 No
10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	hat Country?
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11. Meritel Status  1 Never Merried 2 Marrie  3 Widowed 4 Divorced	12. Wes Decede Armed Force at   Yes 2[ If Yes, Give Year or Dete	XNo	3. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 No	en, Mexican, Puerto	pecify Yes or No- Pican, etc.)		- American Indien, , White, etc.
15. Decedent's	s Education	16e. De	cedent's Usuel Occu	pation	viae	16b. Kind of Bus	
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17. Father's Neme (First, Middle, L. Lawrence Edw		ho1+#			Elizabe		
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21. Signeture of Funeral Service Li	icarisee 1		22. Name end Addr Grove Fune	ess of Fecility			
Kadu	the		141 W.Mair			1750-036	58
			sequence of):		1		my fore men
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Cause (bisease or injury that initiated events resulting in death) Last  Pert II. Other significant condition  25. Wes case referred to medical examiner?  1 Yes 2 No  27. Menper of Death 1 Naturel 5 Pending investigs 2 Accident 3 Suicide 6 Could not determine (Check only one)  29e. Certifier (Check only one)	Hospitel: 1 Inpi  28a. Dete of t (Month, ation of be ned 28e. Plece of building,	Due to (or es e con  Due to (o	sequence of):  sequence of):  e underlying ceuse g  ttient 3□ DOA Or e of 28c. Injury M 1E street, fectory, office	26. Place of Deether: 4 Nursing Hury et ork? Yes 2 No	23b. Did to 1 Y 24e. Wes e perfor 1 Y th (Check only or ome Resid 28d. Describe h 28l. Location (S City or Tow	obacco use conversed No on eutopsy med?  ance 6 Other ow injury occurrent of Number of Stete)  ause(s) and mer ate end place, a	tribute to the cause of death  3 Probably 4 Unknown  24b. Were autopsy tindings eveileble prior to completion of ceuse of deeth?  1 Yes 2 No  or (Specify)  and
if eny, leading to immediate cause. Enter Undertying Cause (Disease or Injury thet initieted events resulting in death) Last  Pert It. Other significant condition  25. Wes case referred to medical examiner?  1 Yes 2 No  27. Menoper of Death 1 Death investigated inv	Hospitel: 1 □ Inparation of be ned 28e. Plece of building, 1 Physician: To the be parminer: On the basis	Due to (or es e con  Due to (o	sequence of):  sequence of):  e underlying ceuse g  ttient 3□ DOA Or e of 28c. Injury M 1E street, fectory, office seth occurred et the trinvestigation, In my 29c. Licer	26. Place of Deether: 4 Nursing Hury et ork? Yes 2 No	23b. Did to 1 Y 24e. Wes e perfor 1 Y th (Check only or ome Resid 28d. Describe h 28l. Location (S City or Tow	obacco use conversed No on eutopsy med?  ance 6 Other ow injury occurrent of Number of Stete)  ause(s) and mer ate end place, a	tribute to the cause of death 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1 Yes 2 No  or (Specify) and  or or Rural Route Number.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year HHORACE G. RETTEW FEBRUARY 22,2000 09:10AM 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson If Linder 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1)() M 2 F 081-12-3473 Yrs. 78 Jan. 29,1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County-Towson Baltimore Maryland 1 ☐ Yes A No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 21204 1055 W. Joppa Rd. USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pace - American Indian, Black, White, etc. 11. Meritel Status Y Yes 2 No if Yes, Give Year or Dates: WW 11 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop Owner 17. Father's Name (First, Middle, Last) N/A 18. Mother's Name (First, Middle, Maiden Surname) Horace Melrose Rettew Louisa Knec

**Physician** /Medical Examiner

permit. Page Department of Important: If eny Injury or page.

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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**Funeral** 

Director

Hygiene. other than "natural", or hama 23a or ent, the Medical Examinations to

Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiene. In the file marked other than "natural", or he iry or other traumatic avent, professional Entities.

Baltimore, Maryland 21215-0020

with the Maryland r 28a-f show

death

Examiner Physician/Medical by Completed Be

burial-transit 88 USB director. Certification: To funeral filled in by

The lew requires that the deeth certificate be executed pug Box 68760. P.O. ate has been signed by the a page 2 should be detached f Records, certificate Division of Vital or Attending Physician: this After

within 24 hours after death. To the Funeral Director: A Hospital completely ag ag 2

DHMH 16 Rav 6/95

State Registrar

Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Manner of Death

(Check only one)

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

19a. Informant's Name/Relationship (Type, Print)

21. Signature of Funeral Service Licensee

X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

Bonnie Rettew

20a. Method of Disposition

25. Waa case referred to medical Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1X Yes 2 No

1 Natural 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Cartifier

5 Pending

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

29b. Signeture and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEWART R. FINNEY 7505 OSLER DRIVE S-306 TOWSON, MARYLAMD 21204 31. Date filed (Month, Day, Year)

FEB 2 4 2000

32. Registrar's Signature oaks

20b. Place of Disposition (Name of cemetery, crematory or other place) 2-25-2000 Baltimore, Md. Dulaney Valley M. G.

22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 23a. Pert1. Enter the disèase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death

Date

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Gailridge Rd. Timonium, Md. 21093

AORTIC DISSECTION

Due to (or as a consequence of)

HYPERTENSION

Due to (or as a consequence of):

Due to (or as a consequence of):

28b. Time of

23b. Did tobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

20c. Location - City or Town, State

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

HOURS

YEARS

2 No 1 Yes

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

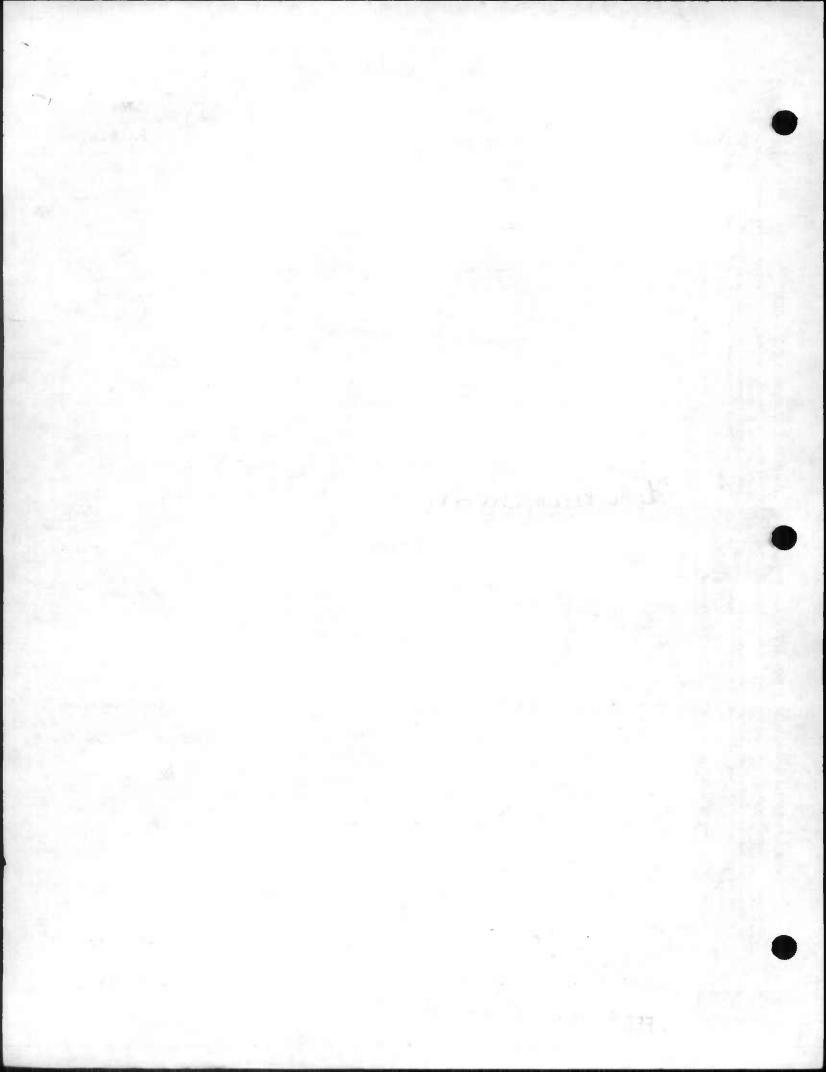
29d. Date signed (Month, Day, Year)

00

28c. Injury at Work?

29c. License number

D38655



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 17, MAY AUGUSTA CARLYN REINHARDT FEBRUARY 2000 5:15 AM 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) Months Days Hours 1 M 20 F Maryland 217-22-1667 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County Maryland Baltimore 1 ☐ Yes 2 ☐ No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8801 Mayflower Rd. 21237 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 11 Meritel Status Bleck, White, etc. 1 Yes 2 No 1 Never Merried X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Homemaking-Own Home 10th grade 17. Father's Name (First, Middle, Last) N/A Homemaker 18. Mothar's Nama (First, Middle, Maiden Sumame) Augusta Selliers Carl Mohr 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 Mayflower Rd. Baltimore, Md. 21237 Joseph R. Reinhardt (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Zion Church Cemetery 2+21-2000 Baltimore, Md. 21. Signature of Funeral Service Licen 22. Name end Address of Fecility Lassahn Funeral Home 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS 4 DAYS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 🗆 Yas 2000 2 No 25. Was case referred to medical axaminer? 26. Piace of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation Natural 2 Accident

Examiner physician and s the burial-transit that the death certificate be execu 68760 Box P.O. à signed t Records. certificate Division of Vitai at or Attending Physician: T s after death. If Director: After this certificat ed in by the funeral director, p

**Physician** 

/Medical

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Funeral

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**Funeral** 

Director

'natural', or Items 23s or 28s-f show

Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hydi Important: if Item 27 is merken any Injury or other.

**Physician** /Medical

Examiner

72 hours after

altimore, Maryland 21215-0020

Physician/Medical þ Completed Be Certification: To edical

3 Suicide

29a. Certifian

4 Homicida

To the Hospital within 24 hours a To the Funeral Completely filled

filled

State Registrar

29b. Signature and title of certified

6 Could not be

D 37254

1 Yes 2 No

Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 00

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM. M. D. , 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

31. Dete filed (Month, Day, Year) 32. Registrer's Signature FEB 2 4 2000 2cm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Virginia Daisy Renner February 22, 2000 2:30 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Wood Nursing Center Rossville Baltimore If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 10 M 2 F 217-03-0444 88 Vrs 11, 1911 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1 ☐ Yes 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 St. Marys Road 21221 United States Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11 Marital Status 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Brooks Rosie A. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4910 Bay Street N.E. Apt. 302 St. Petersburg FL George D. Brooks (Brother) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 2/25/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Parkwood Cemetery Milton J Knight Jar 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland Leonard J. Ruck, Inc. 5305 Harford Rd. 21214 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one ceuse on each line. not enter the mode of dying, such as cerdiac or respiratory errest, Approximata Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) RESPIRATORY INSUFFICIENCY 2 YEARS Due to (or as e consequence of) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred

Physician /Medical Examiner be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Herne 23s or 28a-t show

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hours after

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permit. Pages 1 and 2 ahould be file.
Department of Health and Mental Hy important: if flew 27 is marked other any Injury or other.

Baltimore, Maryland 21215-0020

Box 68760

P.O. I

Records,

Division of Vital

Director

Funeral

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Physician/Medical þ Completed Be

and attending physiclan for use as the buria signed by t page 2 should peed certificate the Hospital or Attending Physician: thin 24 hours effer death. the Funeral Director: After this certifica mpletely filled in by the funeral director; Certification: To edicai

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

State Registrar

5 Pending

investigation

6 Could not be

D.O.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number H35593

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) FEB. 23, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed an of death (Item 23a) (Type, Print)

1124 Mace Avenue Dr. John J. Loh M.D. Baltimore, Maryland 21221

31. Date filed (Month, Day, Year) FEB 2 4 2000

29b. Signature and title of certifier

1) Matural

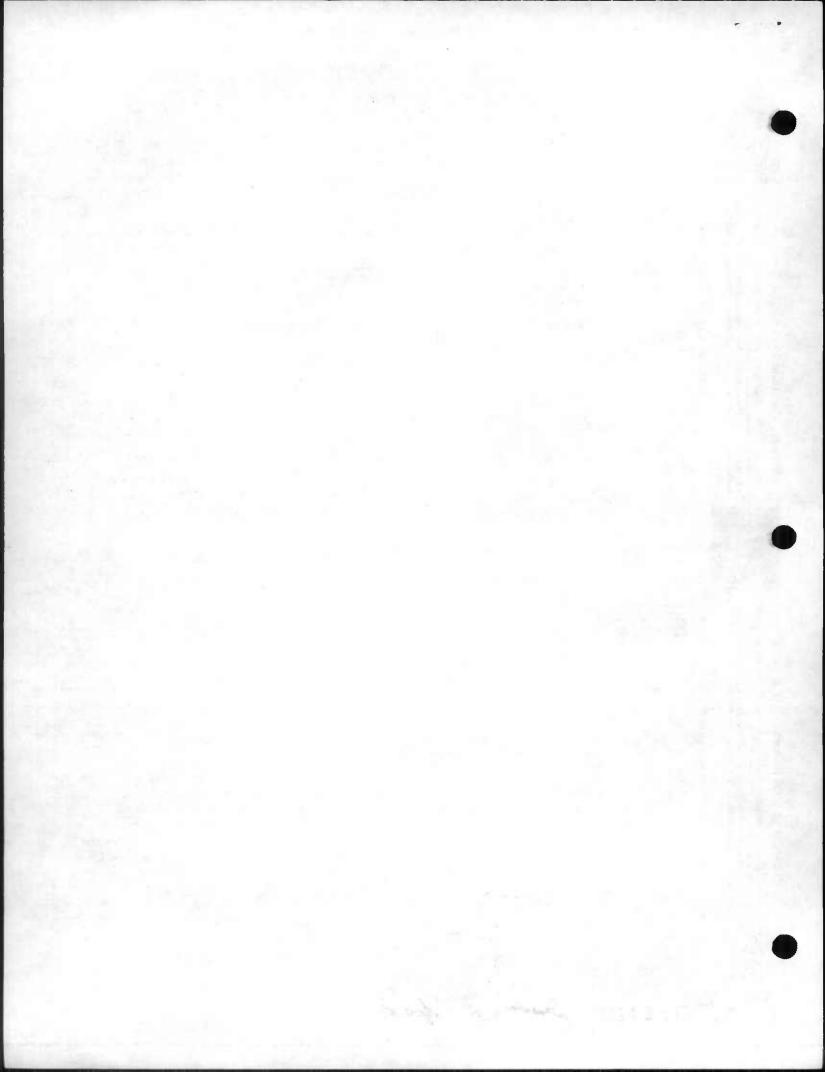
2 Accident

4 Homicide

3 Suicide

29e, Certifie (Check only one)

32. Registrar's Signature



Records, P.O. LUROTHYM. BORKOSK of Vital Division

**DHMH 16 Rev 6/95** 

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked othe any Injury or other traumatic avent place.

**Physician** /Medical

Examiner

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To the Hospital within 24 hours a To the Funeral D

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Examiner

Physician/Medical

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Certification:

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Saltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) FEB 24 2000

Joseph

29b. Signeture and fittle of certifier

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moran 900 COSON 32. Begistrar's Signature 0

C.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

pus BATIMONE MO 21227

29c. License number

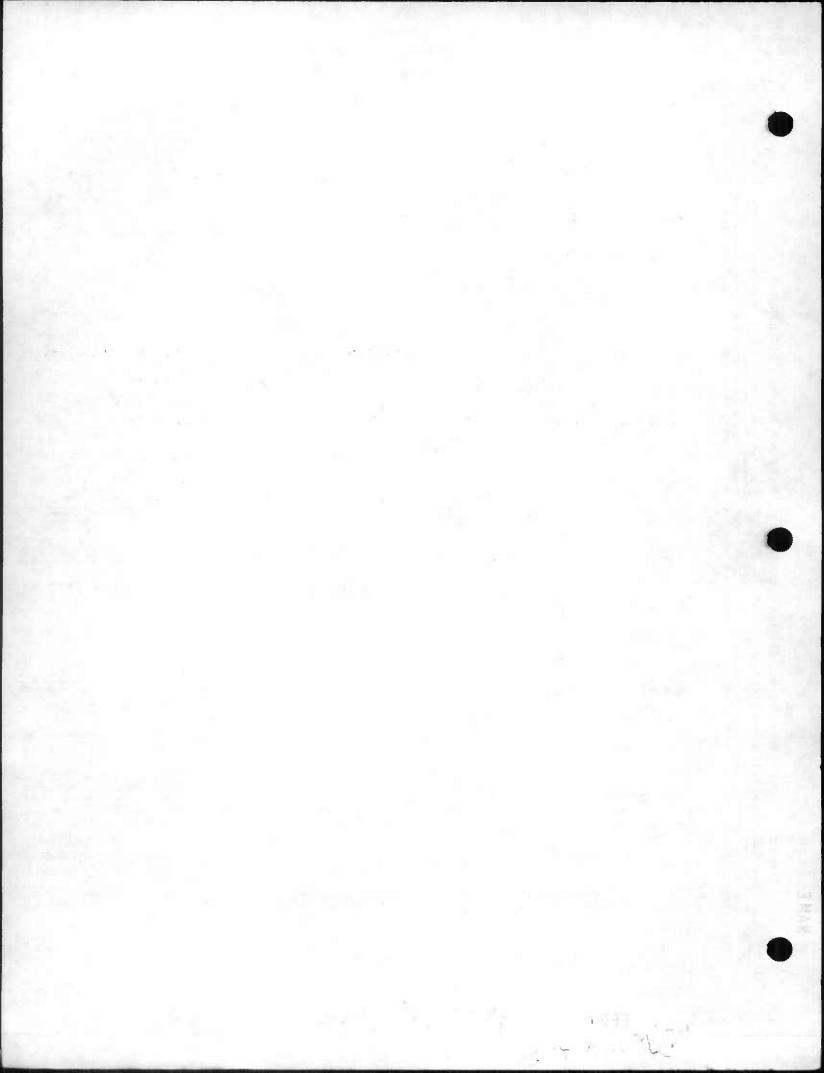
29d. Date signed (Month, Day, Year)

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Self-	State of Maryland / Department of Health and M  Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. No.	06033
Physician /Medical	James F. Reese	Month Dey February 22	year 2000 6:30 P.M.
Examiner  Funeral  Director			ne Arundel  9. Birthplace (State or Foreign Country)  Maryland
M Wand	Usuel Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Maryla a or 28a-f show be notified at Director	Maryland Anne Arundel Severna Park		1 ☐ Yes 2 No
	10e. Street and Number  5 Woodbent Drive  10l. Zip Code  21146		of What Country?
OO20 writ, or ster death w unit, or stern 23s al Examiner must) d by Funeral	11. Manitel Stetus  12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 Married 3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Yesr or Detes:  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Race - American Indien, Bleck, White, etc.
Maryland 21215-0020 12 should be filled within 72 hours at h and Marrist Hygiens. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12th  College (1-4or 5+)  Shipping Manager	ng	of Business/Industry
Be G		(First, Middle, Maiden Sur	
To I	David E. Reese Ma  19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurs	rgaret Marie	
Ma aith ar 27 ls or tress			Maryland 21146
Baltimore, Peges 1.1 Separtiment of He mportant. If Item my injury or other side.	20e. Method of Disposition  1	Dete 20c. Locati	on - City or Town, Stete
Box 68760, auth certificate be executed attending physician and for use as the burish-transit clan/Medical Examiner	234. Part 1. Enter the disease, or compelications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List party one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or es e consequence pf):  Due to (or es e consequence of):		
P.O. unithe of other seasons when the other seasons when the other seasons with the other s	Part other elgrificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Whetes Mellifus ~ Type #F	23b. Did tobacco use	contribute to the cause of death?
The law requires the law been signed page 2 should be Completed by	Swallowing Dystanction	24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Ri delan: The i certificate hu rector, page	25. Was case referred to medical 26. Place of Death	1 Yes 200	lo 1 Yes 2 No
DIVISION OF or Attending Physical Birector: After this in by the funeral of ertification: To	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hot 1 Natural 5 Pending (Month, Dey Year) 28b. Time of Injury Work?  28a. Dete of Injury 28b. Time of Injury Work?  1 Yes 2 No	me 5 ☐ Residence 6 ☐ 28d. Describe how injury or 28f. Location (Street end N City or Town, State)	
n 24 hours n 24 hours pletsly fill edical	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of my knowledge, deeth occurred at the time, date and place, and menner steled.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and menner steled.	end due to the cause(s) and ed at the time, date and pla	d manner as stated. ice, and due to the cause(s)
tot with w	290. Signature and title culturally 29c. License number  29c. License number  D52728	Febru	igned (Month, Dey, Year)
State Registrar	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)  ### Rand ## 30 L Swema Park, M  31. Date fined World, Cay, Year,    32. Registrer's Signature   32. Registrer's Signature   33. Registrer's Signature   34. Care   35. Registrer's Signature   35. Registrer's Signature   36. Registrer's Signature   36. Registrer's Signature   37. Registrer's Signature   38. R	D 21146, J	ohn F. Loome, Mil

DHMH 16 Rev 6/95

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Emily Russell February 22 2000 9:53 P.M. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Hospice of the Chesapeake Linthicum Anne Arundel If Linder 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Hours 1 □ M 280 F 216 28 4073 Yrs. 68 Feb. 26, 1931 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zln Code 10g. Citizen of What Country? 7900 Benesch Circle Apt. 808 21060 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2X No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Title Examiner Dept. of Motor Vehicle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Pramschufer Viola Sparks 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilie Caldwell / Daughter 20 Country Club Drive Glen Burnie, Maryland 21060 20b. Plece of Disposition (Name of cemetery, cremetory or other placa) 20c. Location · City or Town, Stete 20e. Method of Disposition Dete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Glen Haven Memorial Park 2/25/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funerel Service Licensee Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 romerousk 23a/Part1. Enter the disease, a semplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Parietal-Temporal Brain Gliothree Immediate Cause (Finel diseese or condition resulting in deeth) months DI as to pue to for es a consequence of: " F ORM & Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert It. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert It. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

permit. Page Department of Important: If eny Injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Herna:

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Il Hygiena.

Pages 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 is marked out

hours after

altimore, Maryland 21215-0020

Director

Funeral

Completed

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physician and s the burial-transit Attending Physician: Certification: To death.

Box 68760.

P.O.

Records,

Division of Vital

or Attendation of the original of the original

an 24 hour. the Funeral Direction of the filled in br

To the Hosp within 24 ho To the Functional

Physician/Medical Completed Be

Examiner

25. Was case referred to medical 1 Yes 2 No

29a. Certifier

(Check only one)

29b. Signature end title of certifier

27. Menner of Death 1 Neturel 5 Pending 2 Accident 3 Suicide

Investigation 6 Could not be determined 4 Homicide

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Plece of hijury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

House 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated.

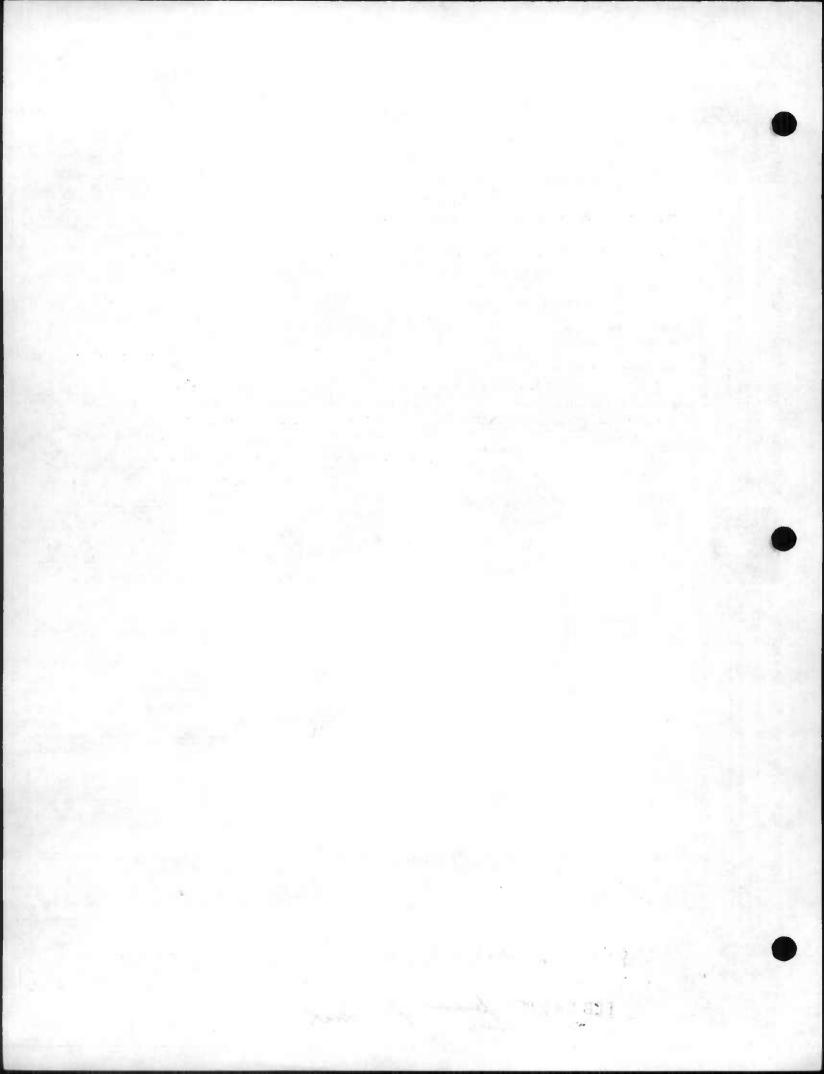
29d. Date signed (Month, Dey, Year)

Rosemarie

29c. License number

State Registrar

Medical

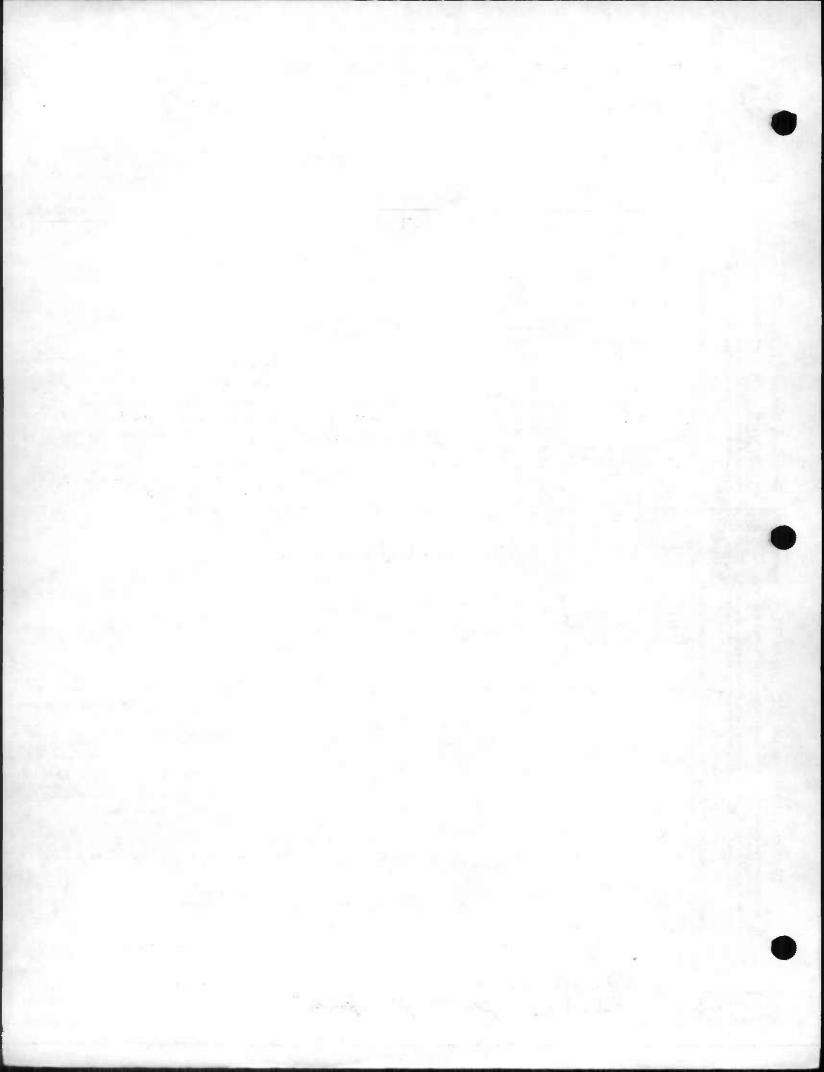


00-0608-510

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Physiciar /Medica	_	HARLAN ROWE							Month FEBRUA	ARY 2,20	Year 00	1:45P.M.
Examine		la Facility Name (If not institution, g	ive street and nu	ımber)			4b. City	, Town, or Lo	ocation of Dea			
		325 YALE AVE						IMORE		N/A		
Funeral Director		5. Sociel Security Number 6.  unknown  Usual Residence of Decedent	Sex 1⊠M 2□F	7. Age (In yrs 74		months (	Year If Un Days Hou	der 24 Hrs. irs Min.	8. Date of Bi (Month, D unknow)			lace (State or Foreig itry) inknown
and a show	1	10a. Stete 10b. County  unknown  MD	wn N/A	10c. C	unkı	or Location  NOWN  IMORE						0d. Inside City Limit: t\OI Yes 2 □ No
at be not	5	10e. Street and Number 325 Yale Road				10f. Zip C	21229	9		10g. Citizen of	1	
	ò	11. Maritel Status unknown 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 No		13. Was Deceder If Yes, specify	t of Hispanic Cuban, Mex	Origin? (Sp tican, Puerto	ecity Yes or N Rican, etc.)	o- 14. Rad Bla Specif	ce - Americ ck, White, by: Wh	
Medical I	Completed	15. Decedent's Elementary/Secondery (0-12)	Education		16a. D	Decedent's Usual ( Give kind of work of life. DO NOT use	Occupation done during i retired)	most of work	ing	16b. Kind of B	lusiness/Inc	dustry
and and	E O	unknown	unkno			unknow	n			un	known	
1 1 1 1	90	17. Father's Name (First, Middle, Las	t)				18. M	other's Nem	e (First, Middle	e, Maiden Sumar	ne)	
affic ev	0	unknown						un	known			
at traum		19a. Informant's Name/Relationship O.C.M.E.	(Type, Print)			Meiling Address (S			timore,	the second second	, State, Zip 201	Code)
repartment of re important: If lian any injury or oth anse.	2	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3    4 ☐ Donation 5 🖾 Other (Special Content of the Cont		Stete	Place of D cemetery,	Disposition (Name , crematory or othe	of er place)		Date	20c. Location	- City or To	wn, State
200		Ronald S	Wade	Directo	or	22. Name end	Address of Fa	Board	655 W	. Baltin	nore !	Street
ysician Medical aminer		23a Pa 11. Enter the disease, or conshock, or heart feilure. List only immediate Cause (Final disease or condition resulting in death)	inplications that of	eroscier	ath. Do no	Baltimo	re, MD of dying, such	2120 n as cardiac	)1	. Baltin	more :	Approximate Interval Between Onset and Death
Medical aminer properties of p	ical Examiner	23a Pal(1. Enter the disease, or conshock, or heart feilure. List online in the constant of th	inplications that of	caused the deceach line.  CFG SCIER  Due to	ath. Do no	Baltimo of enter the mode of	re, MD of dying, such	2120 n as cardiac	)1		nore	Approximate Interval Between
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his certificate has been signed by the attending physician and idirector, page 2 should be detached for use as the bunki-transit in page 2.	reducing the completed by Physician Medical Examiner	23a Palt1. Enter the disease for conshock, or heart feilure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pert II. Other algnificant conditional axaminer?  12 Yes 2 No  25. Wes case referred to medical axaminer?  17 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigeting a suicide 4 Homicide 1 Could not determine (Check only 2 Medical Examiner)  29a. Certifier 1 Certifying P	hyplications that a yone ceuse on a a. And b. c	Due to Due to Due to Injury At Ing. etc. (Special Injury - At Ing. etc. (Special Ing. etc	ath. Do no  (or as a co  (or as a co  (or as a co  esulting in the control of the	Baltimo of enter the mode of any icuasic onsequence of): onseq	re, MD of dying, such  KAR  See given in P  26. P  Other: 4  Injury et Work? 11 Yes  office	2120 has cardiac as ca	23b. Did  1 24a. War peri  1 Check only me 5 Res 28d. Describe  28f. Location City or To	I tobacco use co I Yes 2 No s an autopsy ormed?  Yes 2 No one) iidence 6 Ott how injury occu (Street and Num own, State)	24b. Wave of 11 and 12	Approximate Interval Between Onset and Death Onset and Death Onset and Death D

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Santella 23 **FEBRUARY** 2000 01:02 A.M. /Medical 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 171-07-8277 7. Age (In yrs. last birthday). 86 Yrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □VF Months Days Director 11-1-13 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Baltimore Rosedale 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 8304 B Philadelphia Rd. 21237 USA Funerai 14. Race - American Indian, 11, Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 X No Specify: Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard Baltimore County permit. Pages 1 and 2 should be file Department of Haalth and Mental Hys Important: If flem 27 is marked othe eny injury or other traumatic avent, pance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 8 unknown John Pompa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Santella / son 1511 Carriage Hill Dr. Westminster, MD 21157 altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 2-26-00 Dundalk, MD 22. Name and Address of Facility CVach/Rosedale Funeral Home 21. Signature of Funeral Service License 1211 Chesaco Ave. Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that caused the thinth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset end Deeth Physician CARDIO BULMONARY ARREST Immediate Cause (Finat disease or condition resulting in death) /Medical 45 min Examiner Examiner certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MOCARDIAL INFAKTION Box 68760. Physician/Medical tha ANEUKYSM REPAIR P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 27. Manger of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vitai

MARV

SANTELLA

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

DHMH 16 Rev 6/95

State Registrar

20b. Signature and tale of certifier

6701

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

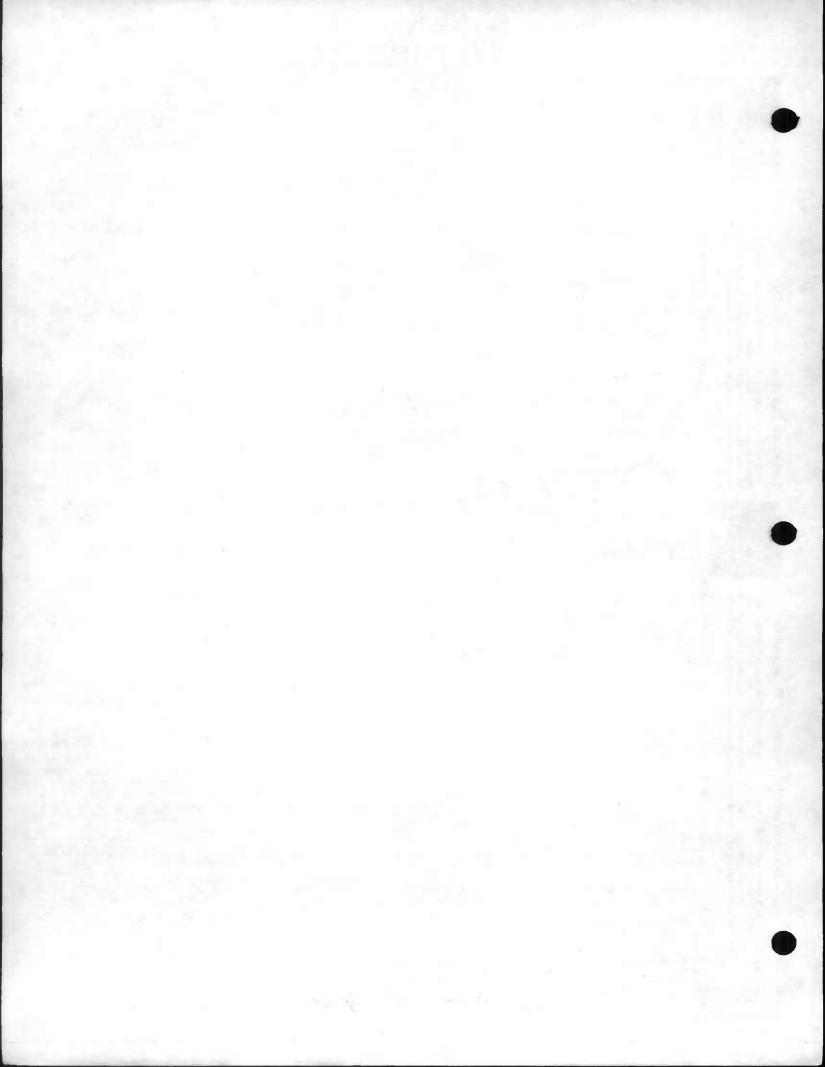
BAZTIMORE

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed Month, Day, Year)



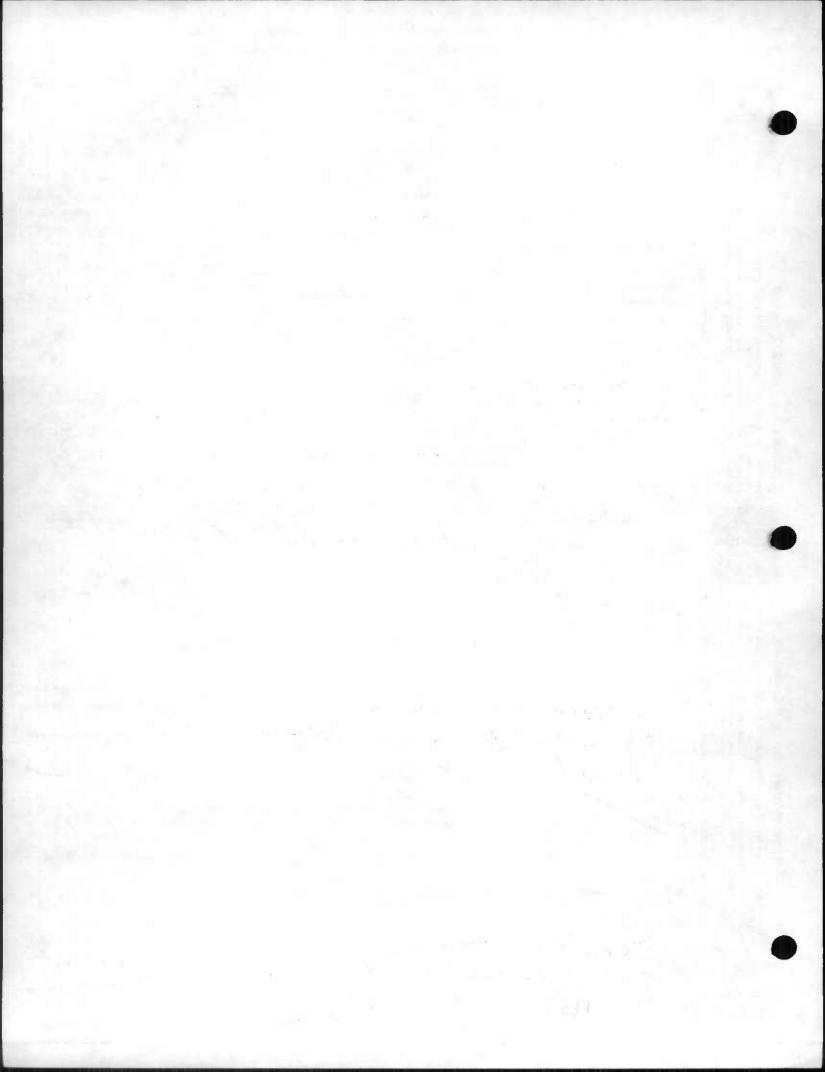
Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06037 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Peb. 22, 2000 **Physician** Myrtle M. Shreve 11:35 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug 14, 1917 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1 □ M 2 Ø F 214-44-1249 Aug 82 W. Va. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 💢 No Director 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? must be n 863 Turf Valley Drive 21122 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: þ 3 ⊠ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. filled within Elementary/Secondary (0-12) College (1-4or 5+) Home Owner 11 th Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Heart; if them 27 is marked oth jury or other traumatic even Be Dora A. Scott William J. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 863 Turf Valley Drive Pasadena Maryland 21122 Naomi Smith (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Cedar Hill Cemetary 2-25-00 Brooklyn Park Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mc Cully Polyniak Funeral Home P.A. ton 3204 Mountain Road Pasadena Md. 21122 receive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ecoudit inferetion **Physician** Immediate Causa (Final diseasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of): for use signed by the a d be detached f P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mic heart discase 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, Vascular Disens 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Mellites 2 3 No 2 4 No or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 THM 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Within 24 hours after death.

Forthis Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 6ky Bunics 2106 pompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person a

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State Registrar

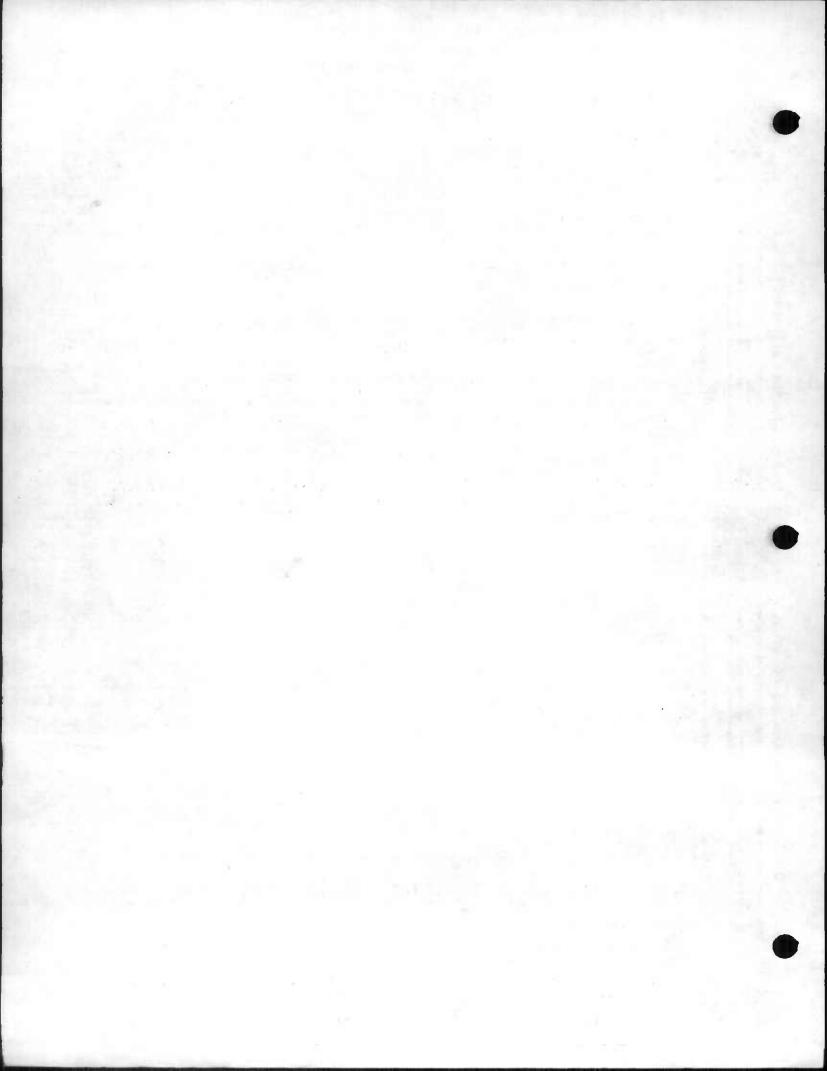
32. Registrar se ignature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

				State of IMa	arylanu / I	Certificate of			ig. No.	06038
	Physicia /Medic		Decedent's Name (First, Middle, Las MADELINE	E E	SASS			2. Dete of Death Month Februar	Day	Year 5:10 AM
	Examin		4s Facility Name (If not institution, give Mariner Health an		f N. Ar	undel	4b. City, Town, or Lo Glen Burn		4c. County of	Arundel
	Funeral Director		220-14-7204	ex	75	thday) If Under 1 Year Months Days		8. Date of Birth Month, Day, Jan 18,	1925	9. Birthplece (State or Foreign Country) Maryland
Saltimore, Maryland Z1Z15-00Z0  emit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland	Manyland and ahow iffed at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. Stete 10b. County  Maryland N.A.		10c. City, Tow Balti					10d. Inside City Limits 1 🖔 Yes 2 🗆 No
	ith with the Maryler 23a or 28a-f ahow Lat be matified at		10e. Street and Number 3813 Brooklyn	Avenue		10f. Zip Code	21225	10	og. Citizen of WI USA	
	off, or he		11. Marital Status  1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Wes Decedent of If Yes, specify Cut  1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White
	within 72 ha		15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire 3 a ker	pation during most of work ed)	ing	Baker	
	2 T 50 A		17. Father's Neme (First, Middle, Last) John	Sas	ss		18. Mother's Nem		feiden Sumame WCZYNSk	
	and 2 sho ealth and I n 27 is me her treume		19a. Informent's Neme/Relationship (7 Mr. Stanley Schaf		ner) 3	Meiling Address (Stree 8813 Brookly		altimore	, Md.	21225
	permit. Pages I Department of H Important: If ites any injury or oth DDCS.		20a. Method of Disposition  1 □/Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	)	Glen F		al Pk. 2/2			nie, Maryland
Q Q	Department Important: any injury DDCS.		21. Signature of Fuperal Segrice Licen			McCully-P 237 E. Pa	olyniak F	uneral e., Balt	Home, P	.A. 21225-1856
4	Physician /Medical Examiner		23a. Part1. Enter the disease, or companies, or heart failure. List only of the list only only only only only only only only	· Pn	luni	Owa consequence of):	ing, such es cardiac	or respiretory arre	st,	Approximate Interval Between Onset and Deeth
ien: The law requires that the death certificate be executed rifficate has been signed by the ettending physician and ctor, page 2 should be detached for use as the burist-transit	g physicia as the bu	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	epha	consequence of):				2 week
	at the cean of the attendetached for us	Be Completed by Physician/M	Part II. Other significant conditions co		it not resulting i	n the underlying cause gi	iven in Part I.			tribute to the cause of death? 3 Probably 4 Unknown
								248. Wes en	n autopsy ned?	24b. Were eutopsy findings available prior to completion of cause of death?
	ertificata ha ector, page 3		25. Was case referred to medical examiner?				26. Place of Deet		s 28 No	1□Yes 2☑No
10 11016		ation: To	Manne Death  Matural 5 Pending  Accident Investigation	1 Inpatied 28a. Dete of Injur (Month, Day		Firme of njury 28c. Inju		me 5 Reside 28d. Describe ho		
	urs after de rel Directe illed in by t	Certification:	3 Suicide 6 Could not be determined	building, etc	. (Specify)	rm, street, factory, office		City or Town	, State)	er or Rurel Route Number,
100	ifthin 24 hours	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☐ Medical Exam  29b. Signature and title of cartifier	reiclan: To the best of Iner: On the basis of and manner ste	examination an	, death occurred et the ti d/or investigation, in my 29c. Licen	ime, date and place, opinion, deeth occurres on mber	ed at the time, de	ite end place, ai	nner es stated.  nd due to the cause(s)  (Month, Day, Year)
	100		30. Name and address of person who c	Mi	oth /leas age	D	2630-			
1	Stat		Dr. Rani S. Kari 31. Date filed (Month, Day, Year)	pineni, M	.D. 40		s Rd., Ba	Itimore,	Md. 2	1227
	Registra		FEB 2	4 2000	Jenewas.	13. pp	ach			

DHMH 16 Rev 6/95

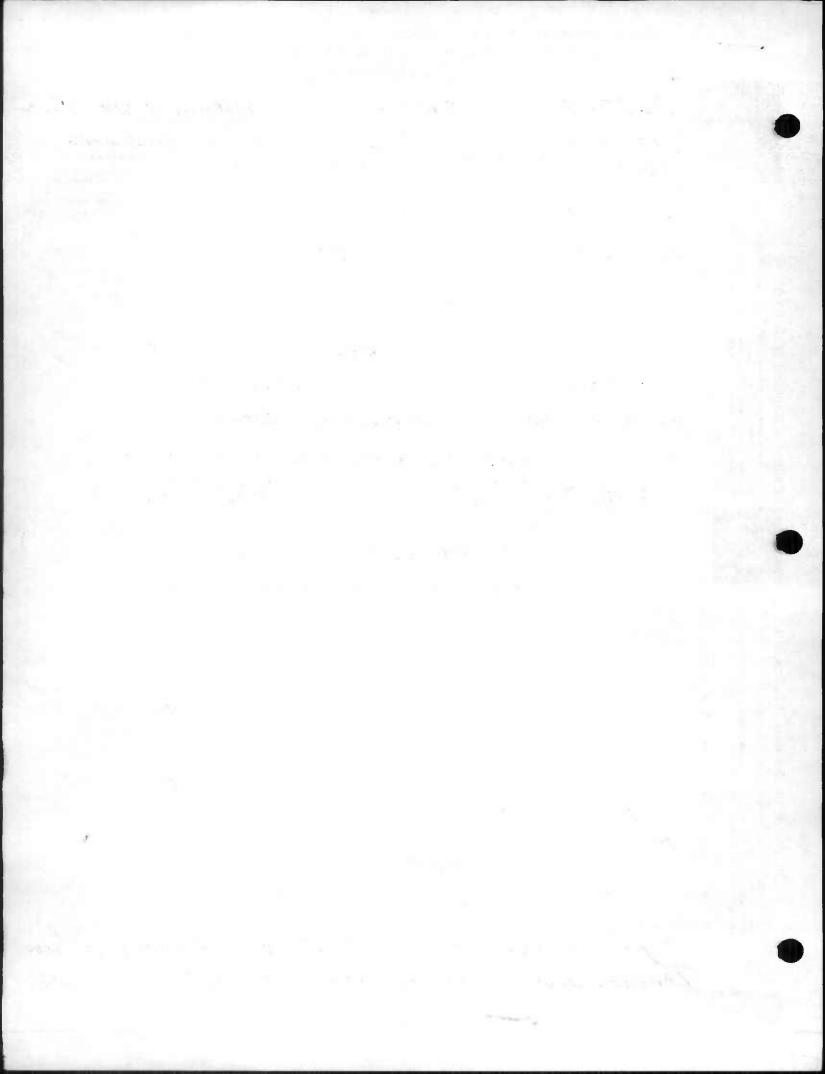


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** LBERT 6.33 Am FEBRUARY 18, 2000 /Medical 4e. Fecility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE
If Undar 24 Hrs. 8. Data of B SAMARITAN HOSPITAL BALTIMORE 5. Social Sacurity Number 8. Data of Birth (Month, Day Yeer) 03/29/1919 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** 10XM 2□ F 217-09-0310 Director Baltimore, MD Usual Residence of Decedent 10e Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show N/A Director Baltimore 1X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 5000 Hillburn Ave. USA 21206 Items 23a Funerai 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 □ No if Yes, Give Year or Datas: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American indian, Black, Whita, atc. 11 Marital Status trsumatic event, the Medical Examiner filed within 72 hours eftar 1 ☐ Nevar Married 2X Married 21215-0020 6 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced natural', Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Hydraulics Engineer 12 Baltimore, Maryland the first of Haalth and Mental H.

It: If item 27 is marked other

y or other forms 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Peges 1 and 2 should be Joseph Siemek Veronica Yurrek 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5000 Hillburn Ave. Baltimore, MD 21206 Mrs. Jane Siemek / Wife 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any injury or once. 4 Donetion 5 Other (Specify) Enterbment Dulaney Valley Mem. Gardens 2/21/2000 Timonium 22. Name and Address of Fecility Ruck Towson Funeral Home Inc. 21. Signature of Funerel Service Licensea Matthew T. Canapp 1050 York Rd. Towson Md 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlac or respiratory errest, shock, or heart feilure. List only one change in each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical immediete Ceuse (Finel CARDIAC APRITHMIAS diseese or condition resulting in death) Examiner CARDIOMYOPATHY The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest the burial-tren P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? this certificate has Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel death. 1 Yes 2 No neral Director: A 3 Sulcide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) or A 4 Homicide To the Hospital within 24 hours a To the Funeral D edical 12 Certifying Phyelclen: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29e. Certifier 29b. Signature applitting of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P12557 of person who completed cause of deeth (Item 23e) (Type, Print) LOCH RAVEN BLUD, BALTIMORE MD 21239 DODOO 5601 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95



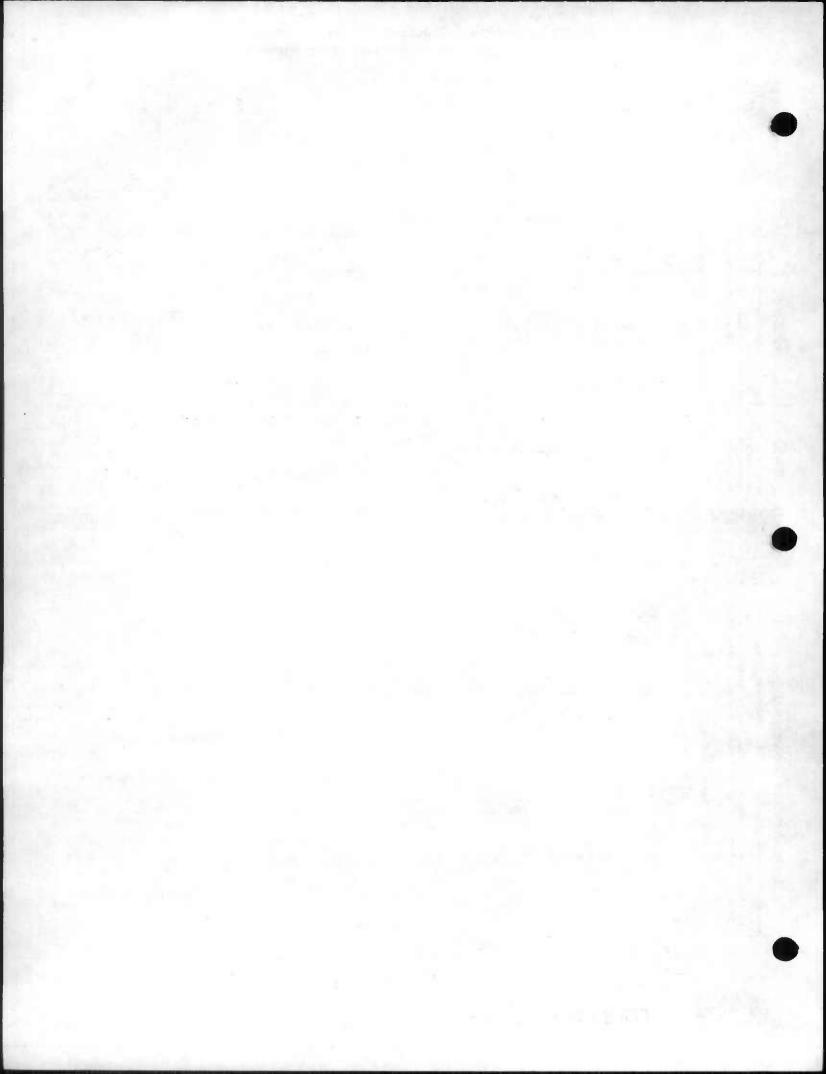
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dorothea Laura Slotke February 2000 9:28 AM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Homes of Lutherville Lutherville Baltimore Co. If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) January 15, 1900 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F Baltimore, Maryland 215-50-9164 100 Director Usuel Residence of Decedent the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Co. Cockevsville Director 10e. Street and Number 10/ Zin Code 10g. Citizen of What Country? 10329E Malcom Circle 21030 United States of America Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours effer 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 n/a Home Maker Own Home permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If flem 27 is marked other any injury or other traumatic event bace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert August Lange Elizabeth Jaeger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Robert W. Slotke(Son) 2314 Killoran Road Timonium, Maryland 21093 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Loudon Park Cemetery 02/26/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RUCK TOWSON Funeral Home, Inc. 21. Signature of Funeral Servica Licenses 1050 York Rd. Towson, Md. 21204 an 23a. Party Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 3 Probably 4 Unknown 1 Yss 2 No Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No 1 Yes 2 No 1 ☐ Yes certificata Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Netural 5 Pending Investigation death. 1 Yes 2 No NA n 24 hours after death re Funeral Director: A bletely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 21,00 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ouk York Towson

DHMH 16 Rav 6/95

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrer's Signature



9 Records,

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The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

Director

Funeral

PY

Completed

**Funeral** 

Director

the Maryland

Peges 1 and 2 should be filed within 72 hours after deeth with the Manyfan nent of Health end Mental Hygiene.
and: If Item 27 is marked other than natural; or thema 23a or 28a-f show my or other traumate event, the Model and the fraction of the fraction

permit. Pege Department of Important: If any injury or once.

**Physician** /Medical

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(Check only one)

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page 2

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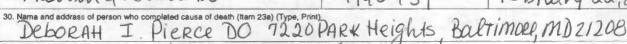
Saltimore, Maryland 21215-0020

Division of Vital or Attending Physician: death. after death Director: 24 hours a Hospital To the To the To the

> State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) FEB24 2000



32. Registrer's Signeture

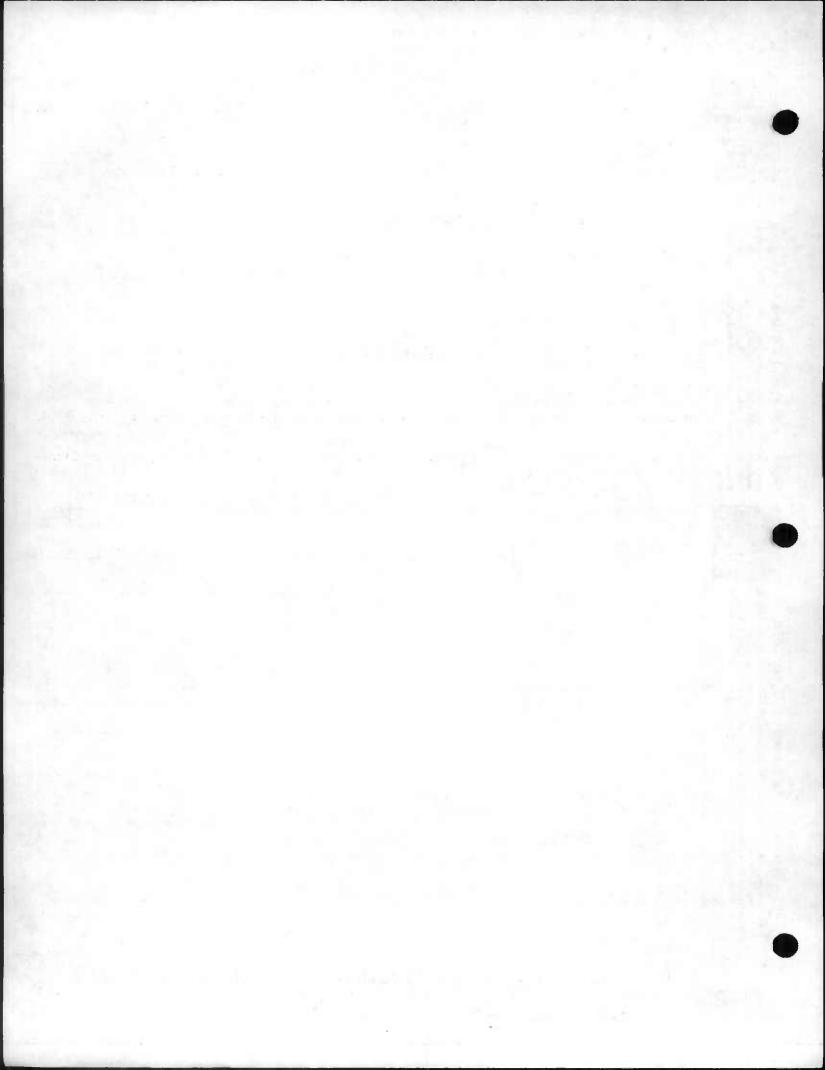
1 Certifying Physician: To the best of my knowledga, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mennar steted.

29c. License number

29d. Data signed (Month, Day, Year)

Fobruary 22,2000



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06042. Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 10:00 A.M. Februar 2000 Norma Elizabeth Schafer 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosadala Baltimore If Under 24 Hrs. If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stele or Foreign Country) Days Months Hours 1□M 2X F Yrs 215-12-4255 79 19,1920 Oct. Perryville.MD. Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 9809 Gunforge Road 21128 U.S.A. 12. Was Decedent Evar in U,S. Armed Forceş? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 79 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 yrs. N/A Housewife Homekeeping 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George Amoss Jones Maude Garretson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9809 Gunforge Road Mr. John P. Schafer (Wife) Perry Hall, MD. 21128 20b. Place of Disposition (Nama of cematary, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 2/22/2000 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 21. Signeture of Funaral Service 22. Nama and Addrass of Facility E.F.Lassahn Funeral Home pesa 0. 11750 Belair Rd. Kingsville, Maryland 21087 23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only one ceusa on each line. Approximete Intarval Between Onset and Death Immediata Causa (Final Hypoxamia Hours disaasa or condition rasulting in daath) Dua to (or as a consequence of): Kaspivatory Failure Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Pheumonia Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary 3 Probably 4 Unknown 1 Yee 2 No 24b. Were autopsy findings available prior to Pancreatic Abscess 24a. Was en autopsy completion of cause of death? 20 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas 25. Was case ratarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural 2 Accident 5 Pending Invastigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

Completed

Be

**Funeral** 

Director

tem 27 la marked other than "natural", or flema 23a or 28a-f ahow other traumatic event, the Madical Examinar must be notified at

Important: if Item 27 Is marked other than eny injury or other trainment

CHAFFER, Norma

Examiner that the death certificate be assecuted P.O. Box 68760, Physician/Medicai the for use as 9 2 bengis d be del Completed by Records, certificate Division of Vitai 8 Medical Certification: To this After

Attending Physician: death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu

**DHMH 16 Rev 6/95** 

State Registrar

Muneses Dr. Judel 31. Data filed (Monto, Dey, Year) 32. Registrar's Signature FEB 2 4 2000

6 Could not be

3 Suicide

29e. Certifiar (Check only one)

4 ☐ Homicide

29b. Signatura and try of certifier

30. Nama and advrass of person who complated causa of death (Item 23a) (Type, Print) 9000 Franklin Savara Drive

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29c. License number D53462

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) February 19, 2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, Maryland

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State of Marylan	d / Department of Health and Me	ental Hygiene	10 0604
	Certificate of Death	Reg. No.	

EUGENE STOKLEY		State of M		partment of ertificate of			giene 🕕 [ Reg. No.	0 06043	
Physician /Medical	Decedent's Neme (First, Middle, I     EUGENE A. STOKL     Facility Neme (If not institution, g	EY			4b. City, Town, or	2. Date of De Month  JANUARY  1 ocation of Deet	Dey 31,20		
Examiner Funeral Director	1123 N.STRICKER  5. Social Security Number 6. unknown	STREET	ge (In yrs. lest birthde Y <b>6</b> :	Months   De	BALTIMO er   If Under 24 Hrs	RE 8. Date of Bir		N/A  9. Birthplece (Stele or Foreig Country) unknown	
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urs after deeth	11.23 N. Stricke  11. Meritel Stetus unknown  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces?	Ever in U,S. 1	3. Was Decedent of If Yes, specify C	21217 of Hispanic Orlgin? (Suben, Mexicen, Puel No Specify:	Specify Yes or No to Rican, etc.)	Blee	USAmerican Indien, ck, White, etc.	
within 72 ane. than 'nat	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) Unknown	College (1-4or	(Gi	DO NOT use re	ne during most of wo tired)	orking	16b. Kind of B	usiness/Industry	
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1 and 2 sho Health end I em 27 le ma other treume	19e. Informant's Neme/Relationship  O.C.M.E.  20a. Method of Disposition	(Type, Print)	20b. Plece of Dis	1 Penn S	eet end Number or R	-		, State, Zip Code)  - City or Town, Stete	
permit. Pages Depertment of Important: If its eny injury or o	1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Dother (Specify) In State 21. Signeture of Funeral Service Licensee  Royald S. Wade Director State Anatomy Board 655 W. Baltimore Street								
Physician /Medical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications thet causery one cause on each li	ne.	Baltimor enter the mode of	e. MD 21	201 ac or respiretory e	prrest,	Approximete Interval Between Onset end Deeth	
end I-transit xaminer	resulting In death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Quee, Disease or Injury	b	Due to (or es a con	sequence of):					
3 22 3	Cause (Diseese or Injury that initiated events resulting in death) Last	c	Due to (or es e cons	sequence of):	1				
that the detacher detachery	Part II. Other significant conditions	contributing to death b	out not resulting in the	a underlying ceuse	given in Pert I.		tobacco use co	ontribute to the causs of death	
The law requires that also has been signed I page 2 should be det							en autopsy ormed	24b. Were eutopsy findings eveilable prior to completion of ceuse of death?	
ertific ector, Be	25. Was case referred to medical examiner?	Hospitel:				1 ☐ eath (Check only		1 Yes 2 No	
eath. cor: After this the funeral di cation: To	27. Manner of Death  1 Natural 2 Accident investiget 3 Suicide 4 Homicide	28a. Dete of Inju (Month, De	y Year) Injur	e of 28c. I	njury at Work? I ☐ Yes 2 ☐ No	28f. Location	how injury occur		
To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by Medical Certifi	29a. Certifier 1 Certifying F	Physician: To the best	f examinetion and/or	investigation, in n		e, end due to the		and due to the cause(s)	

25. Was case examiner?	referred	to	medicel
1 to Yes	2 No		

29b. Signeture end title of certified

29c. License number O.C.M.E.

FEBRUARY 1,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODOREMINA 31. Dete filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201

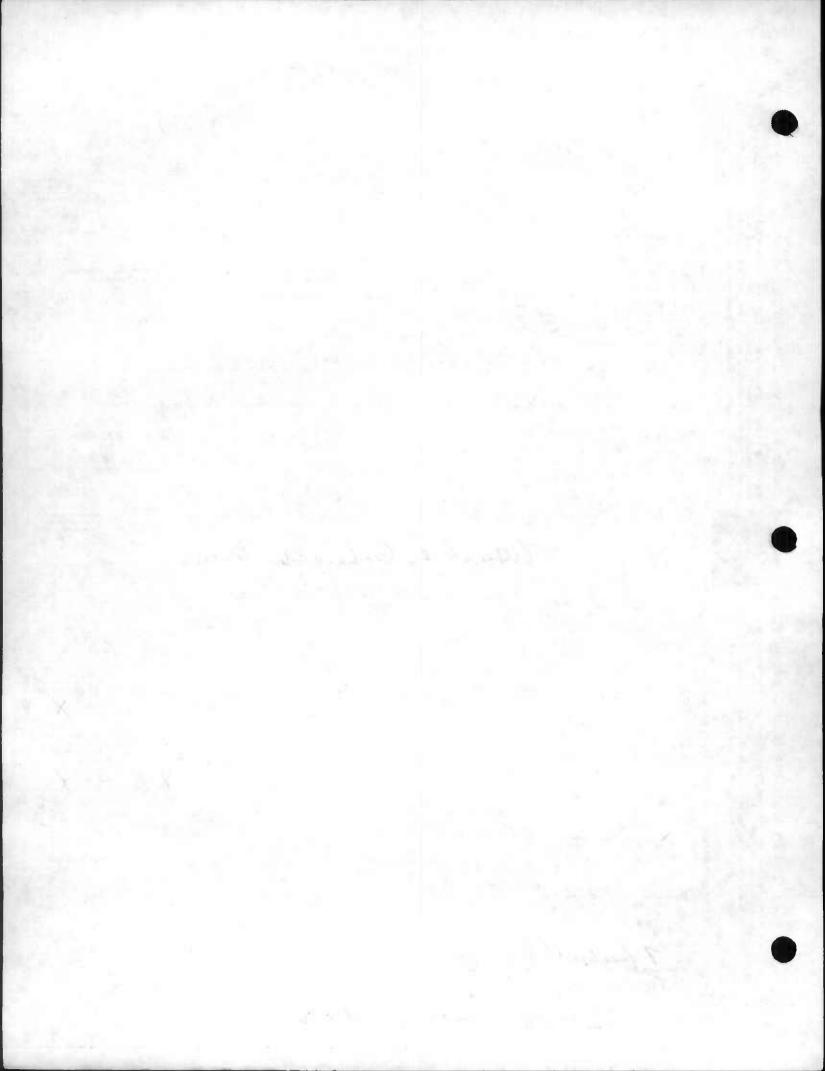
State Registrar

FEB 2 4

32. Registrar's Signeture

**DHMH 16 Rev 6/95** 

Division of Vital



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Doroth 2000 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Edenwald Towson | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | October 19,1922 9. Birthplaca (State or Foreign Country) Parkville, Maryland 5. Social Security Number 6. Sex 7. Aga (in yrs. last birthday) 10 M 20 F 218 18 0022 Yrs Usual Rasidance of Dacedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10e. Street and Number 10f. Zlp Code 10g. Citizan of What Country? 800 Southerly Road Apartment 903 21286 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican indian, 11. Marital Stetus Bleck. White, etc. 1 Yas 2 No it Yes, Give Year or Datas: 1 ☐ Never Married 2 X Married 1 ☐ Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Lady Department Store 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Charles Frederick Radar Amelia Wilhelmina Frankenberger 19a. Informant'a Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Henry N Thampson (Wife) 800 Southerly Road Apt. 903 Towson, maryland 21286 20b. Piaca of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovei from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery February 21,2000 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home 23a. Part. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximata Intarvai Between Onset and Death Immediate Causa (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence ot): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Piaca ot Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpaliant 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Data of injury (Month, Day Year) 28b Time of 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 Naturai

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

Be

2

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introprient: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other treumatic event. The Medical Exemine.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical signed by the attending p þ should Completed page 2 Be

certificata has funeral director. Aftar this

2

Certification:

edical

The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death. filled in by within 24 hours a To the Funeral C completely filled

To the

Registrar

State

mpres 31. Dete filed (Month, Day, Year) FEB 24 2000

2 Accident

3 Sulcide

29a. Cartifier

4 Homicide

29b. Signeture and title of certifier

6 Could not be determined

30. Name and eddrass of person who complated cause of death (item 23a) (Type, Print) Moverne 32. Registrer's Signeture

28e. Place of injury - At homa, tarm, straet, tactory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

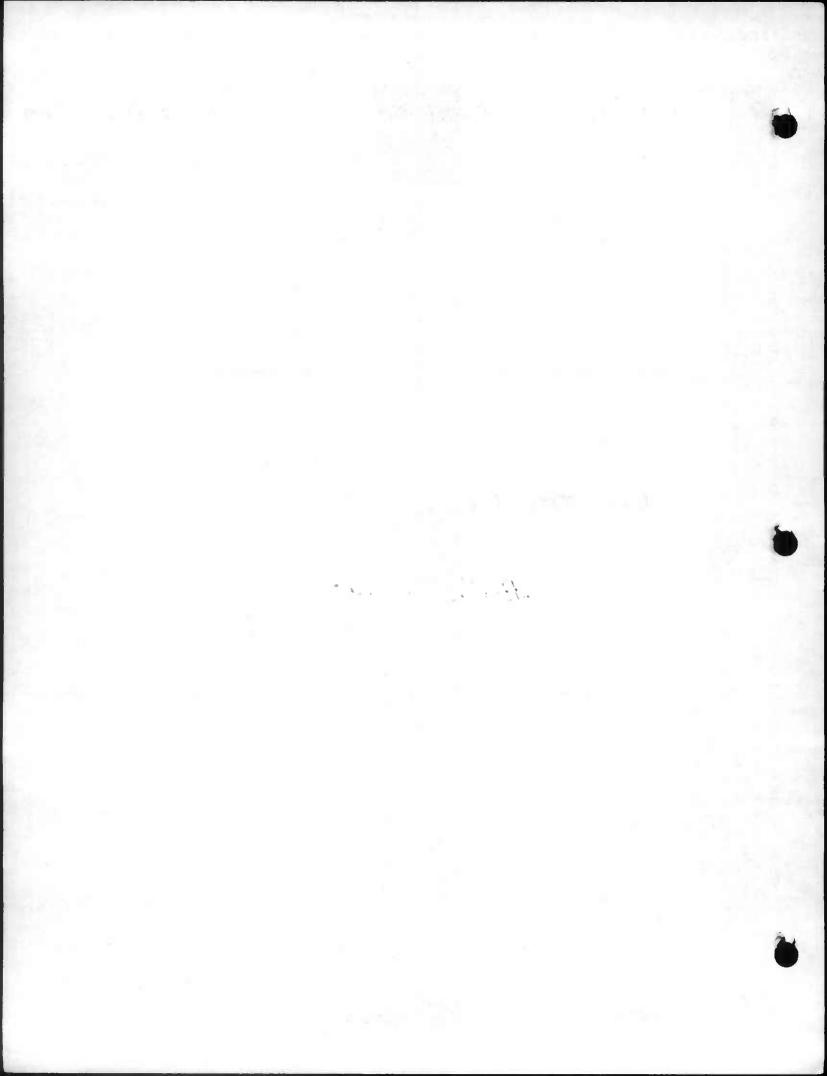
1 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as ateted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licanse number

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Date signed (Month, Day, Year)

DHMH 16 Rsv 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Wenzel 17,2000 tebruary /Medical 4a Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7. Age (In vrs. last birthday) If Under 1 Square 6. Sox tran Klin Birthplaca (State or Foreign Country) 7. Age (In rs. last birthday) 8. Dafe of Birth (Month, Day, 5. Social Security Number Days Months Min. 1X M 20 F Hours 219-32-5881 69 October 02,1930 Liebling, Romania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore Co. Director Maryland Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 North Essex Ave. 21221-4714 Romania Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 04 n/a Hotel Maintenance Hote 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Peter Wenzel 10 Maria Spirk 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Ida Wenzel (nee Kleer)Wife 403 North Essex Ave. Essex, Maryland 21221-4714 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 02/21/2000 Baltimore, Maryland 21. Signature of Euneral Service Licensee Jeffrey L. Gair 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Valer 23a. Paty. Enter the diffusive, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fail. List only one cause on each line. Approximate Interval Between Onsef and Death erebrovascul ar accident 31 Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Examine OSC er Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of al Physician/Medical Due to (or as)a consequence of). 23h. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcide 28e. Place of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Box 68760. certificate be P.O. Records. Division of Vital Attending after death.

Director: Aft
d in by the fur ò To the Hospital o within 24 hours aft To the Funeral DI completely filled in

**Funeral** 

Director

from 27 is marked other than "natural", or from 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 la manked other than any Injury or other trainment.

**Physician** 

/Medical

Examiner

ettending physician and for use as the burial-trensit

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After t

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page 2 ( hes

Baltimore.

State Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

acleman

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

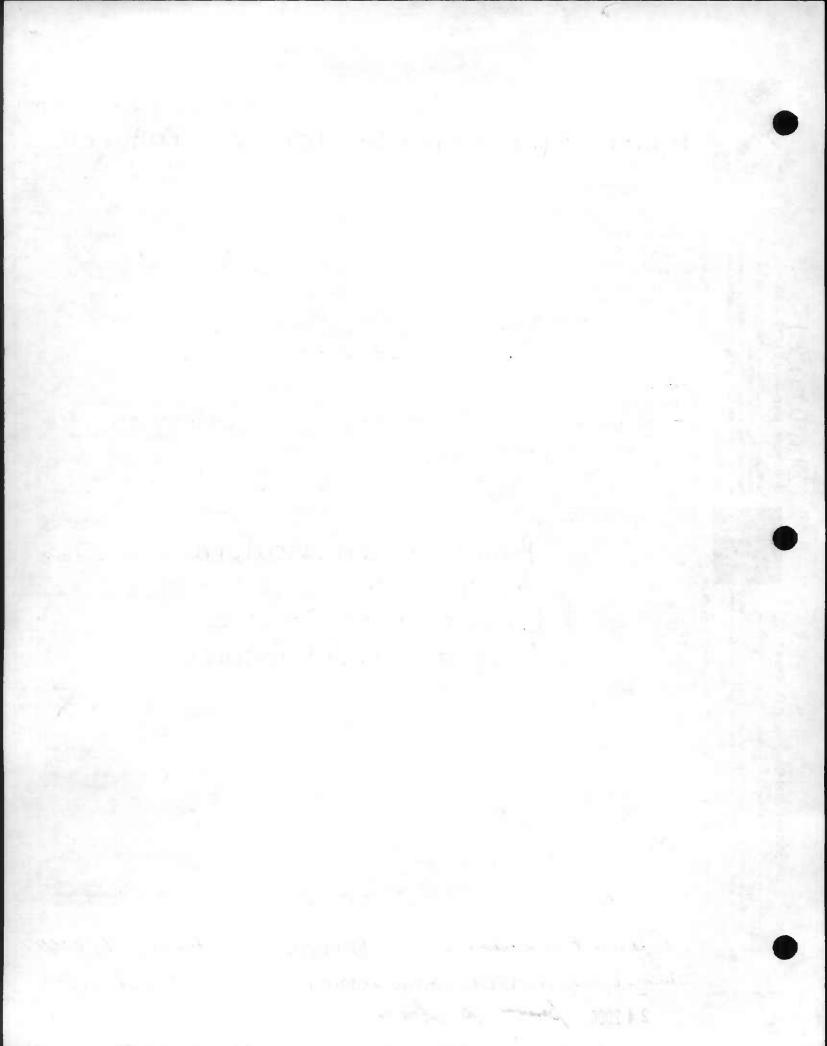
Janine Blackman 9000 Franklin 32. Registrar's Signature

31. Date filed (Month, Day, Year) 2 4 2000

29c. License number RD 198960 29d. Date signed (Month, Day, Year)

February 17,

Square Drive Baltimore Maryland 21237



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Deborah Ann Wilson February 12 2000 9:25 Am /Medical 4b. City, Town, or Location of Death if Under 24 Hrs. 8. Date of Birth Hours Min. May 5, 1960 4a Facility Name (If not Institution, give street end number, 4c. County of Death Examiner OrTH 7. Age (In yrs. last birthday) H Under 1 Year HRUNDEL YNNE HOUNDEL 5. Social Security Number 220-80-9299 9. Birthplace (State or Foreign Mary Land **Funeral** Months Days 1□ M 25 F 39 **Director** Usual Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 108 Highland Road 21060 U.S.A. Funeral permit. Peges 1 and 2 should be filed within 72 hours after deen Department of Health and Mental Hygiene. Important: If them 27 is marked other any injury or other transmitted. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Robert Lo Sugg Joyce Weber 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Sugg (Brother) 391 Dublin Drive Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition t Burial 2 □ Cramation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 2-26-00 Brooklyn Park, MD 22. Name and Address of Fecility Singleton Funeral Home, PA 1 Second Ave. S.W. Glen Burnie, Maryland 21061 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ENCEPHALOPATHI Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last physician and s the burial-tran Due to (or es e consequence of) Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Atter Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigetion Director: 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicida To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signeture and title of certifier

State Registrar

**DHMH 16 Rev 6/95** 

EBBORAL

Box 68760.

P.O.

Records.

Division of Vital

FEB 2 4 2000

ayoka Oxerumi. 301

31. Date filed (Month, Dey, Year)

Hospital Drung Glen Burmo Registrer's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Carlo grade in the Carlo Carlo

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** WOOD ERILY MARGARET EB 21 2000 LINKNOWN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20 BALTI HORE
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) AVENUE ANIER 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** -14-2572 Months Days 1 M 2 XF T. 06, 1914 Director VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND BALTIHORE 1 X Yes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 2 / 2 / 5

13. Wes Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) ANIER AVENUE U5A, Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Bleck, White, etc. ofter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1□Yes 2KNo 21215-0020 Specify: 2 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentel Hyglene. Important: if tem 27 is marked other than "nat any injury or other treumatic event, the Medica page. Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE YRS HOMES Baitimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) RYLAN WILLIE TUCKE LOGAN JENNIE 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) REBECCA WIGGINS 4920 LANIER AVENUE, BALTIMORE, MD. 21215
(Name of Dete 20c. Location - City or Town, Stete SISTER 20a. Method of Disposition Place of Disposition (Name of cemetery, cremetory or other place) 125 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) PARK CEMETERY 02-28-00 BALTIMORE MARYLAND 21. Signeture of Filmeral Service Licensee 22. Name end Address of Fecility JOSEPH H. BROWN FUNERAL HOME JR. AVE 2140 FULTON MD. 212 N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** sudden /Medical Immediate Cause (Finel intention Myscardial disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Theroscherosis -pars physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed to be det Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2☐No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home ... Nursing Home 6 Other (Specify) 9 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3D DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Cartification: After 5 Pending investigation or Attending 1. Natural To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Affe completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner steted. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2067 Oure 2 2-23-00

State Registrar

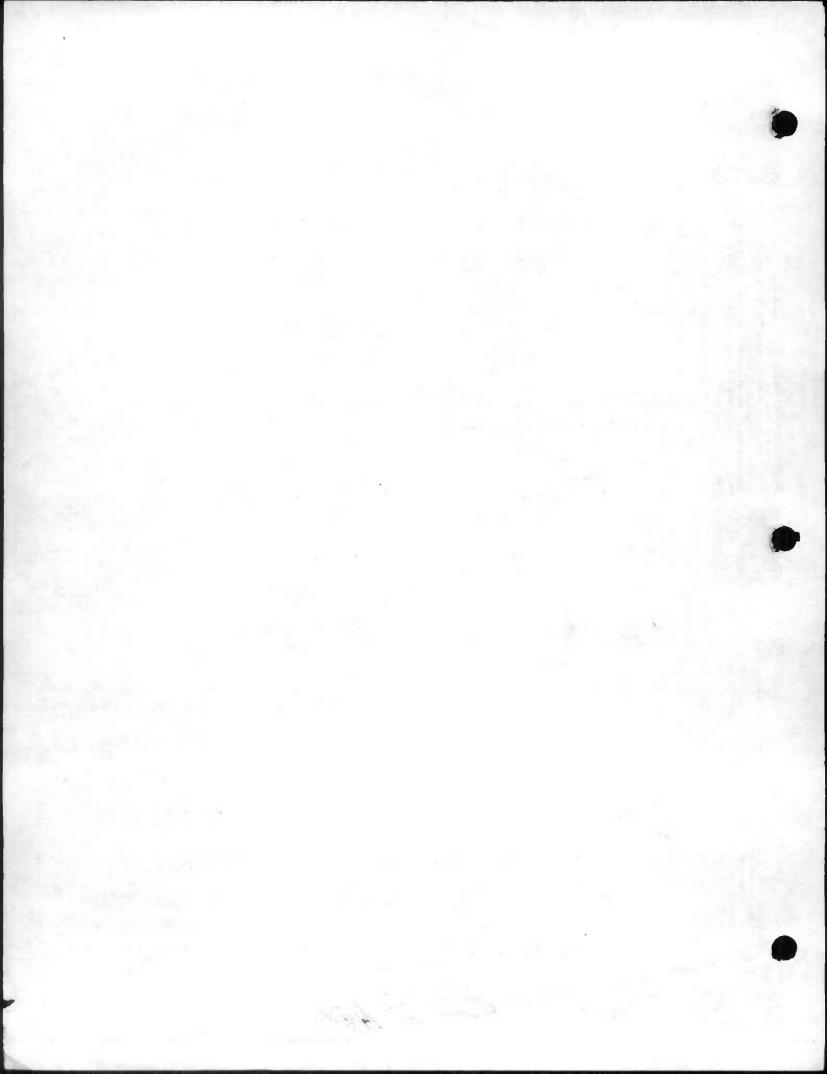
FEB 2 4 2000 DHMH 16 Rev 6/95

reenge 31. Date filed (Month, Day, Year)

7672 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATTHOR, MD 21236



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 4b. City, Town, or Location of Death 7:30A 2000 Pear1 Marjorie Wiseman /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Hospita St. Agnes N/A 5. Social Security Number If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2\ F Months Hours Min Yrs. 83 Nov. 10,1916 Maryland Director 218-07-5703 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f shot traumatic event, the Medical Examinar must be northed at 1 ☐ Yas 2 ☐ No Directo Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3026 Tennessee Avenue 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No if Yes, Give Yaar or Dates: Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, Whita, etc. Pages 1 end 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. Ant: If Itam 27 ie marked other than "natural", or fier ung vy or other traumatic event, fire Medical Exercises ray or other traumatic event, fire Medical Exercises. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Specify: ò 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 6 18 Mother's Name (First Middle Meiden Sumeme) 17. Father's Name (First, Middle, Last) Cornelius William Clarence Reely Dora Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Halethorpe, Maryland 21227 Edwin L. White/ Son 3026 Tennessee Avenue 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Removal from State Department of Important: if eny injury or Meadowridge Memorial Park 2/22/00 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. Manita mas 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part Librer tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner CTROLYTE IMRALAN CE physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): certificete be execu Physician/Medical Dua to (or as a consequenca of): as USe : signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy pege 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yas 2 No Investigation 2 Accident after deatl Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 1🗹 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. To the Vithin 2 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licensa number MEDICAL RESIDENT 5000

SCO AVE APTZB RALTIMORE MP21230

State Registrar

Division of Vital Records,

Wiseman, Kan

Maryland 21215-0020

Baltimore,

DHMH 16 Rev 6/95

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DR BARIFI (
31. Date filed (Month, Day, Year)

FEB 2

OPARE-ADDO 25

32. Registrar's Signature

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daath \_\_ Month 3. Time of Death **Physician** WAGENER 7:23 PM MEGRUARY 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Hillside House Clarksville Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days 1□M 2\ F Vrs August 14,1909 **Director** 213-03-3545 90 Maryland Usuel Residence of Decedent filed within 72 hours efter death with the Marylend Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits \*how r than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Clarksville 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 5502 Harris Farm Lane 21029 United States Funeral 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 1 ☐ Nevar Marriad 2 ☐ Married ☐ Yas 2 No t Yes, Give 1 Yes 25 No Specify: altimore, Maryland 21215-0020 White Specify: by 3 X Widowed 4 ☐ Divorced Year or Datas: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 0 Homemaker Home other item 27 is marked other other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peges 1 and 2 should be fill ment of Health end Mental H lant: If Item 27 Is marked out Be Anthony E. Maczis Mary Herbert 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
8293 7-Mile Drive, Ponte Verda Beach, Jacksonville,
Florida, 32082 19a, Informant's Name/Relationship (Type, Print) John H. Wagener, Jr. - son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition = 5 1 Burial 2 Cremation 3 Removel from Stete permit. Pege Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Othar (Spacify) Meadowridge Memorial Park 2/21/00 Elkridge, Maryland 22. Name end Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue 21. Signature of uneral Service Licensee Baltimore, Maryland 21229 Approximata Intervel Between Onset end Death 23a. Part1. Enter the disease, or complicetions that causad the death. Do not anter the mode of dying, such as cerdied or respiratory arrest, shock, or heart tailure. List only one cluse on each line. **Physician** /Medical Immediate Ceuse (Finel FMENTIA disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner ettending physician end for use es the buriel-trensit that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events rasulting in death) Lest Due to (or as e consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence ot) signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Turknown þ 24b. Were eutopsy tindings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy Completed performed? ils certificate has b director, page 2 s 1 Yes 2 No 1 T Yes al or Attending Physician: Tis effer deeth.

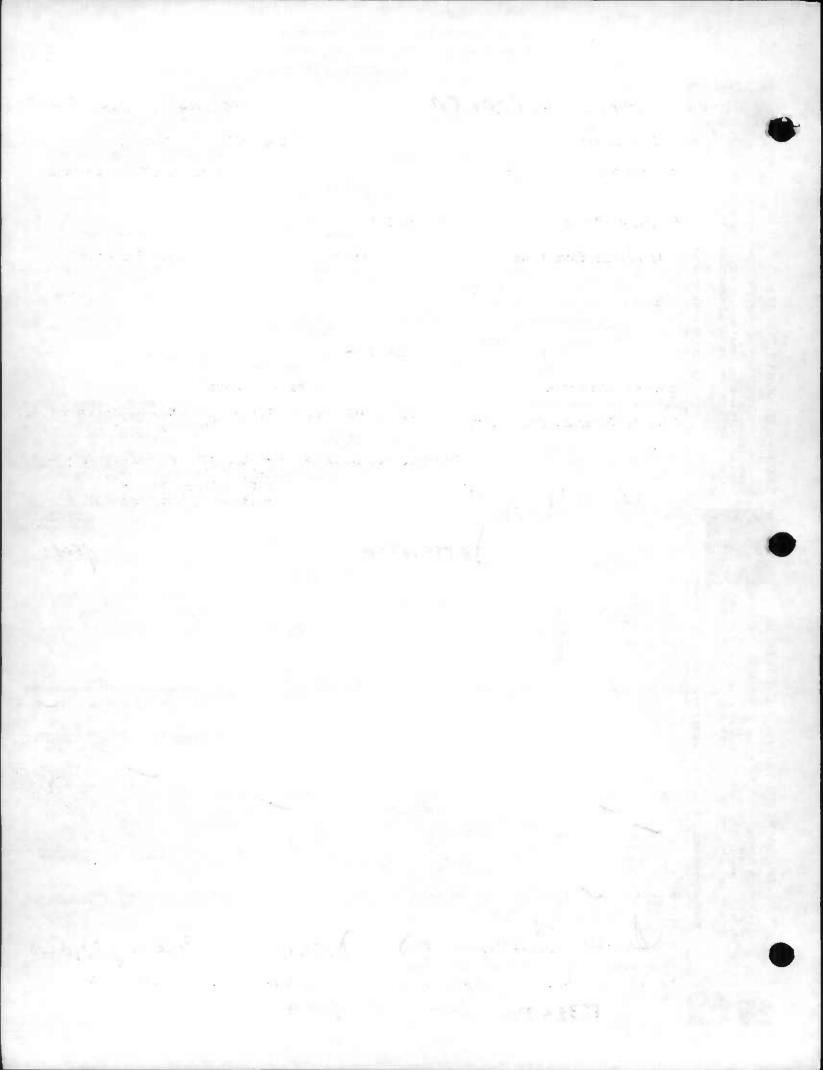
I Director: After this certificated in by the funeral director, pe 25. Wes cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of Certification: 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide in 24 hour. the Funeral Directory Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the causa(s) end manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Dev. Year) 9,2000 udo apaly , tu 30. Name end eddress of person who completed cause ot deeth (Item 23e) (Type, Print) 3905 National Drive, Burtonsville, Maryland 20866 Deepak Cuddapah, 31. Date filed (Month, Dey, Year) 32. Registreds Signeture books

**DHMH 16 Rev 6/95** 

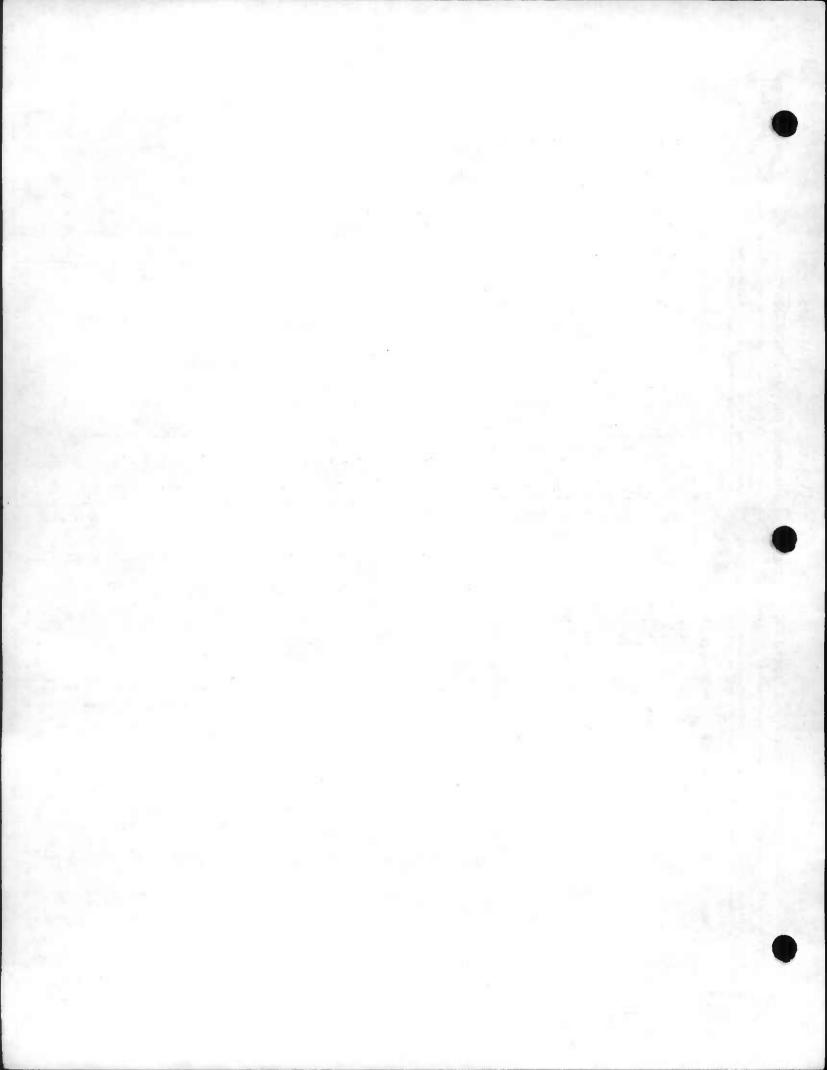
Registrar

FEB24

2000



DHMH 16 Rev 6/95



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da **Physician** Feb. 21, 2000 4:30PM Robert Charles Weaver Jr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 40 Fountain Ridge Circle Apt 2c Parkville If Under 24 Hrs. Hours Min. If Under 1 Ye 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months 213-26-1797 Yrs Director 70 Maryland Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2□ No Md. Parkville 28a-f Directo Baltimore 86 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be b 40 Fountain Ridge Circle Apt 2c 21234 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, al Hygiens. I other than "natural", or flams event, the Medical Examiner in 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 M Yes 2 No If Yes, Give Korean War Year or Dates. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BGE Supervisor Baltimore, Maryland 17. Father's Name (First Middle I ast) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 ahould be fit ment of Health and Mental H ant; if hem 27 is marked off lury or other traumetic even 8 Robert Charles Weaver Sr. Elizabeth May Wolschlager 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3964 Forest Valley Rd. Baltimore, Md. 21234 Stephen V. Weaver / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Feb 23,00 Beltsville, md. 22. Name and Address of Facility 8717 Green Pasters Dr. Baltimore Md. 21286 21. Signature of Funeral Service Licenses Kaura Nardesh CAFA Stephen D. Lohmann P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final Coronary Artery Disease disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner HyperCholesterolemia The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician street Physician/Medical Hypertension Due to (or as a consequence of): been signed by the attending p should be deteched for use as Box Diabetes Mellitus Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 has 1 Yes 2 No 2 K No cartificata 1 Yes Division of Vital Attending Physician: director 25. Was case referred to medical examiner? 8 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Matural e Hospital or Attanding 124 hours after death. e Funeral Director: Aft 1 Yes 2 No 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune compiately fi ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29¢. License number 00 e and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Franklin Square Dr. Ste, 213 Baltimore, MD 21237 Mary E. Carroll M.D.

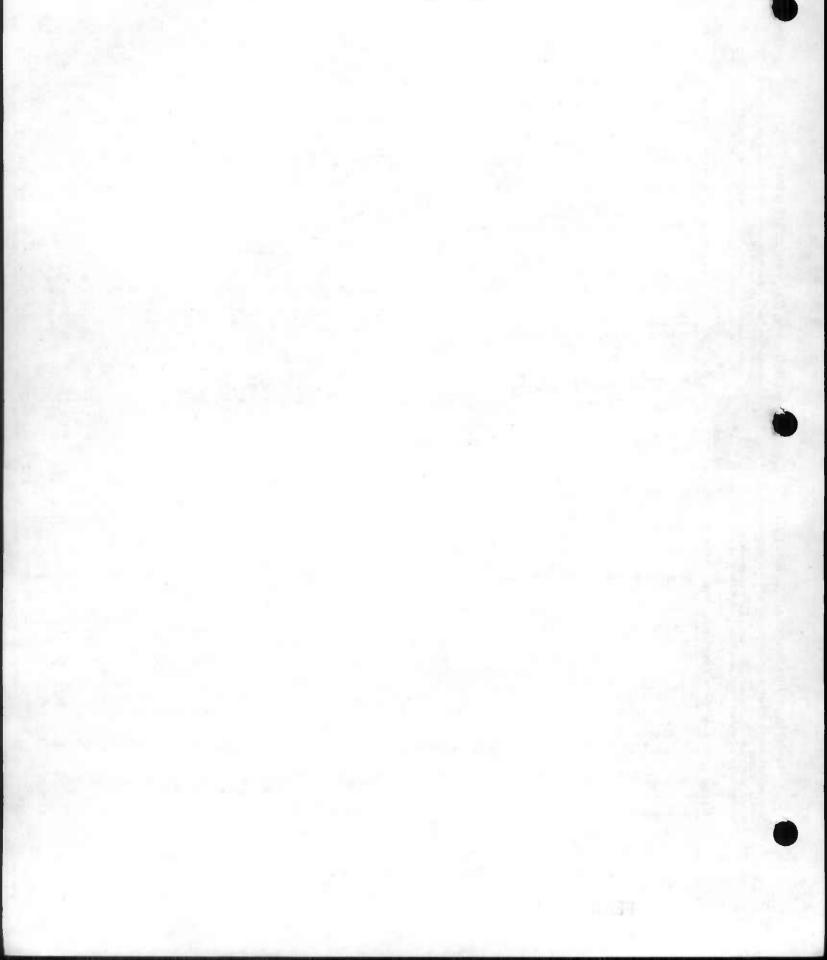
State Registrar

**DHMH 16 Rev 6/95** 

FEB 2 4 2000

31. Date filed (Month, Day, Year)

32. Régistrar's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

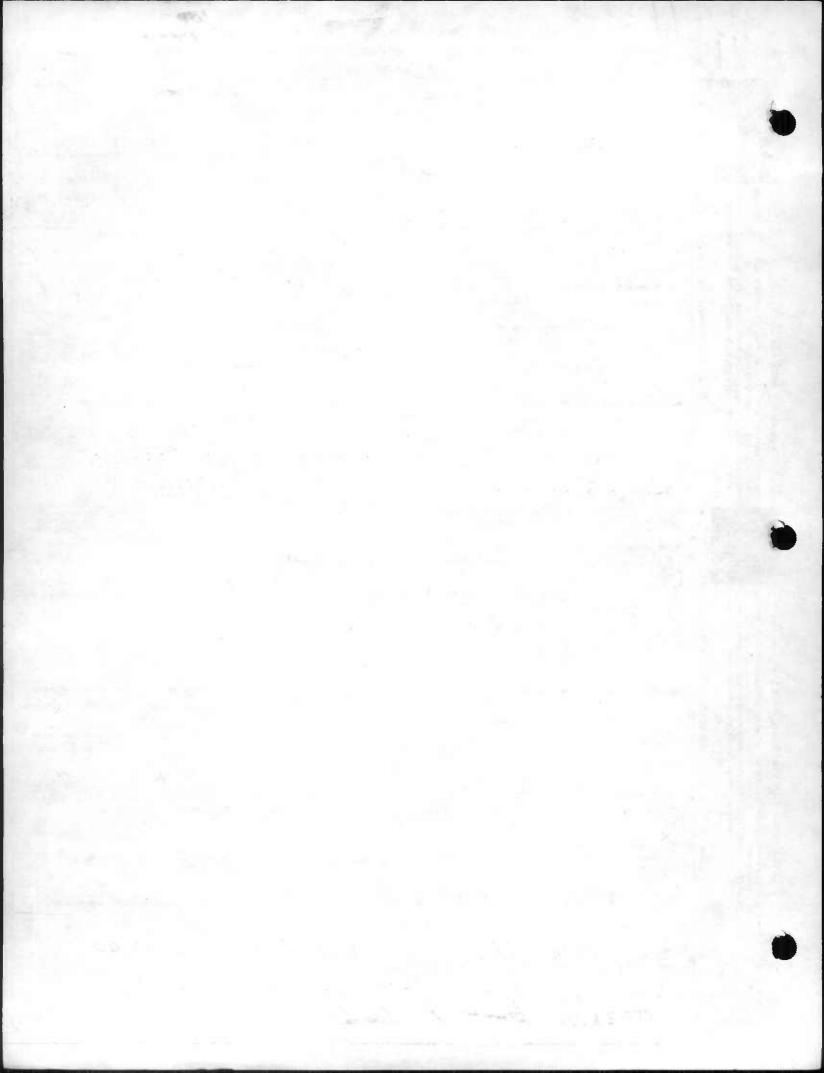
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) Day 22, Month **Physician** JEROME WIDRA 0630 FEBRUARY /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11318 ATLANTIC AVENUE OCEAN CITY WORCESTER If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 214-24-0332 10a State 10b. County 10c. City, Town or Location r than "natural", or Itama 23a or 28a-f ahow the Medical Examples must be notified at 10d. Inside City Limits. 1 Yes 2 No MD. Director WORCESTER OCEAN CITY 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13318 ATLANTIC 21842 AVENUE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 72 hours after 1 XYes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White p 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Company Steel Fabrication 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If them 27 is marked oth eny Injury or other traumatic event ance. Be Charles A. Widra Anna Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4309 Valley View Ave. Baltimore, Md. Marlyn W. Heilman- Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cramation 3 Removal from Stata Gardens Of Faith Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 2/26/2000 Baltimore, Md. 21. Signature of Funeral Service Licensee

Leonard J. Ruc

Gary R. DiGiovanni

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md. 21214 Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Artem scorary Examiner Dua to (or as a consequence of): Examiner nertension Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Aortic Value Dysfunction Box 68760. Physician/Medical Dua to (or as a consequence of): Hyperlipidemin P.O. been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Records. Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 20 No Division of Vital or Attending Physicien: 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding Investigation 1 Natural 2 Accident Ne Hospital or Attending in 24 hours after deeth. 1 TYes 2 □ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified H0053714 90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arue Healtha Berlin IMD 31. Date filed (Month, Dey, Year) 32. Registrar's Signetura Registrar FEB 2 4 2000

DHMH 16 Rav 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

		Certificate of	Death	Reg. No.	00000				
Physician /Medical	Decedent's Name (First, Middle, Last)     Bertha	Watson	2. Date of I Month	Dey Year	3. Time of Death				
Examiner  Funeral Director	213 16 6125 1□M 2⊠F 8	yrs. last birthday) If Under 1 Yea Montha Days	4b. City, Town, or Location of De Grand Burn 1 C r If Under 24 Hrs. 8. Date of E Hours Min. (Month, I	ath 4c. County of Dea ANNE AI Birth Day, Year) 9. Bir	ath , ,				
2	Usuel Residence of Decedent  10a. Stete 10b. County 10c	c. City, Town or Location			10d. Inside City Limits				
28a-f sho notified at rector	Maryland Anne Arundel	Pasadena			1 ☐ Yes 2 No				
2 0	10e. Street and Number 7720 Pine Haven Drive	10f. Zip Code 21	122	10g. Citizen of What C	ountry?				
Examiner must	11. Meritel Stetus  1 □ Never Merried  2 ☑ Merried  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes:	in U,S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yes or ban, Mexicen, Puerto Rican, etc.)  Specify:	Bleck, Whi					
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  9th  College (1-4or 5+)	16a. Decedent's Usuel Occ (Give kind of work don life. DO NOT use retir Homemaker	pation e during most of working ed)	16b. Kind of Business Own Ho					
Be C	17. Father's Neme (First, Middle, Last)		18. Mother's Name (First, Midd	The state of the s					
To To	Henry Miller		Mazie Gr		7: 0.11				
9 0	19e. Informent's Neme/Rejetionship (Type, Print)  Bruce Watson / Husband	7720 Pine Ha	et and Number or Rural Route Num Ven Drizze Pac	sadena, Mary.					
or other	20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from Stete	Ob. Plece of Disposition (Name of cemetery, cremetory or other pl	Dete	20c. Location - City or	r Town, Steta				
any injur	4 Donetion 5 Other (Specify) Hilltop Service Corp. 2/22/00 Towson, Maryland  21. Signature of Funeral Service Licensee Gonce Funeral Home P.A.  4001 Ritchie Highway Baltimore, Md. 21225								
cian lical iner		e heart failur to (or es a consequence or):			Approximate Intervet Between Onset and Deeth				
ise as the burial-transit	if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that injury	y artery d'3 to (or as a consequence of):	ease		years				
detached for us	Pert II. Other significant conditions contributing to deeth but no	t resulting in the underlying cause of		id tobacco usa contribut	te to the cause of death?  Probably 4 Unknown				
2 should be pleased by			24a. W	es en autopsy 24b.	Were autopsy findings evailable prior to completion of cause of death?				
s certificate has director, page 2 To Be Comp			10	Yes 2 No	1 Yes 24 No				
certificate rector, pag	25. Was case referred to medical examiner?		26. Place of Deeth (Check on)						
of in by the funeral director: After this cond in by the funeral director: To	27. Menner of Death  1 Netural 5 Pending (Month, Day Year Park)  2 Accident (Month, Day Year)	28b. Time of linjury W	4 U Nursing Home 5 LI He	esidence 6 Other (Spo be how injury occurred	ecify)				
To the Funeral Director: After completaly filled in by the fune Medical Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - building, etc. (St	At home, ferm, street, fectory, office pecify)	28t. Location City or 1	n (Street and Number or F Town, Stete)	Rural Route Number,				
To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my and menner steted.	knowledge, deeth occurred et the minetion end/or investigation, in my	time, date end place, end due to the opinion, deeth occurred at the time	ne cause(s) and menner a e, date and place, and du	as steted. se to the cause(s)				
comp	29b. Signeture end title of certifier		nse number	29d. Date signed (Mon	nth, Day, Year)				
0	Hwan Gong Jos M  30. Name and eddress of person who completed cause of death	(Item 23a) (Tune Print)	10053514 Hospital	February	20,2000				
		orth Arundel	Hospital						

State Registrar

DHMH 16 Rav 6/95

FEB 24 2000

32. Registrer's Signeture

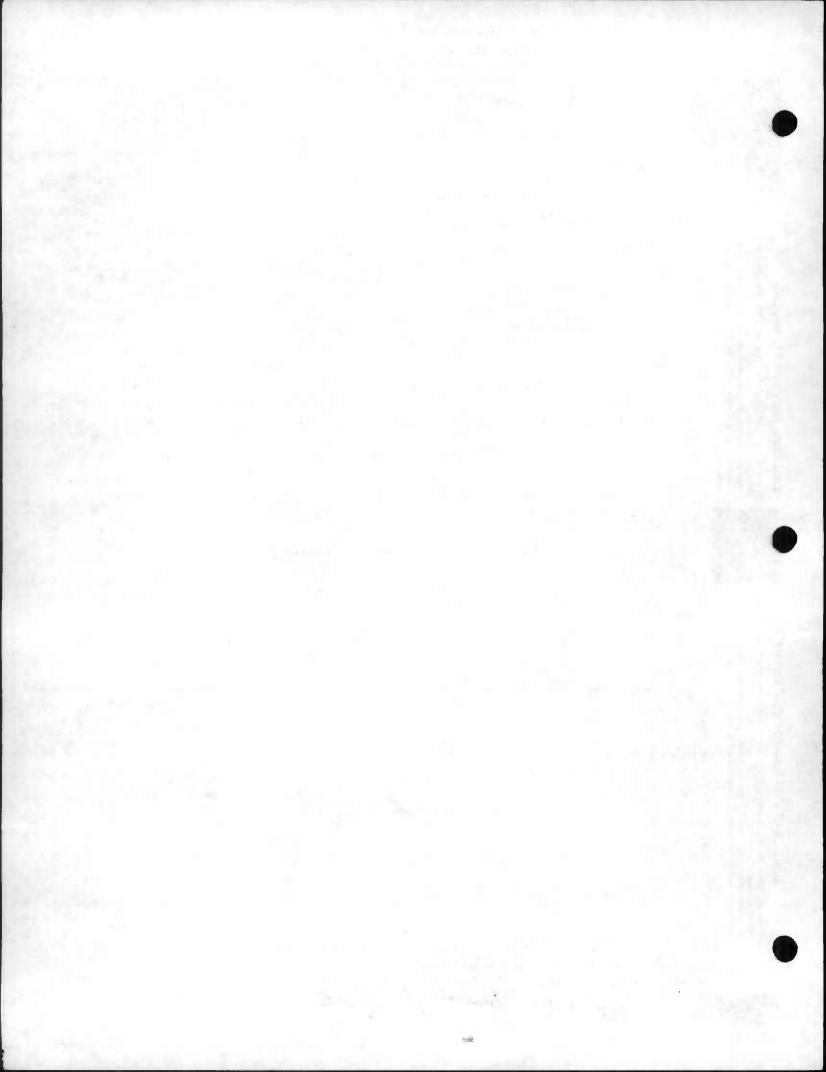
9. Sparks

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 06054

Dev 19 Year 10:05 PM									
4c. County of Death N/A									
Year) 9. Birthplace (Stele or Foreign Country) Maine									
10d. Inside City Limits									
1⊠ Yes 2□ No									
0g. Citizen of What Country?									
U.S.									
r No- 14. Race - American Indien, Bleck, White, etc.  Specify: White									
16b. Kind of Business/Industry									
Montgomery Wards									
Maiden Sumeme)									
Stewart									
, City or Town, State, Zip Code)									
Forest Hill, Maryland 21050									
20c. Location - City or Town, Stata									
Towson, Maryland									
uneral Home P.A.									
lmore, Md. 21225									
SEVERAL YEARS									
bacco use contribute to the cause of death?									
na 2 No 3 Probably 4 Unknown									
n autopsy ned? 24b. Were autopsy findings aveilable prior to completion of cause of death?									
es 2 No 1 Yes 2 No									
e)									
nce 6 Other (Specify)									
ow injury occurred									
reet end Number or Rural Route Number, n, Stete)									
29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.  Check only one)									
ause(s) end manner es stated. ate end place, and due to the cause(s)									
ate end place, and due to the cause(s)  9d. Date signed (Month, Day, Year)									
ate end place, and due to the cause(s)									
ate end place, and due to the cause(s)  9d. Date signed (Month, Day, Year)									

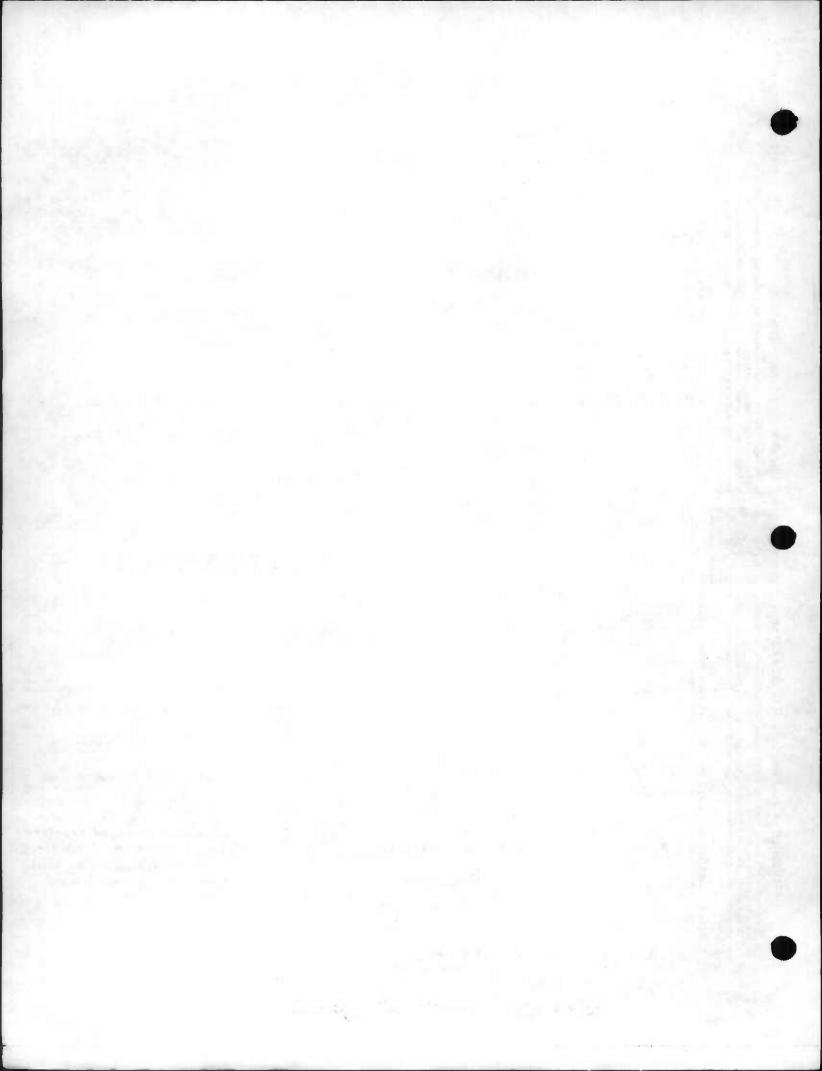
DHMH 16 Ray 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	Decedent's Neme (First, Mi GENE WEDDLE	iddle, Last)					2. Date of D Month	Day	Year	3. Time of Deat
/Medical Examiner	4a Facility Name (If not institu	ition, give street and n	umber)		-	lb. City, Town, or	FEB.	7, 2000 th 4c. County		1729 P
Lxammer	602 WASHING	GTON BLVD.				BALTIMO			/A	
Funeral Director	5. Social Security Number unknown Usual Residence of Decedent	6. Sax 1 □ X M 2 □ F	7. Age (In yrs. las	t birthday) Yrs.	Months Days	H Under 24 Hrs Hours Min	8. Date of B	irth Year) 40	9. Birthplac Country UNKNO	e (State or Ford
MOI III	10a. Stete 10b. Cour		10c. City, 7	Town or Loc	cation				10d	. Inside City Lir
the designation of the correction	MD	N/A		Bal	timore					1 X Yes 2□
23a or 28a-f show unt be notified at rai Director	10e. Street and Number 602 Washin	ngton Blvd			10f. Zip Code	1230		10g. Citizen of W USA		n
er, or Name 23. Example: must by Funeral	11. Maritel Status unknow  1 Never Married 2 N  3 Widowed 4 Divorce	Merried 1 ☐ Yes	2 □ No	1	Ves Decedent of H Yes, specify Cuba		Specify Yes or Note Rican, etc.)	o- 14. Race Blace Specify:	e - American k, White, etc	
nor than "natural, to the Market Completed	15. Deced (Specify only hig	dent's Education phest grade completed	1	16a. Deced	ent's Usual Occup kind of work done of O NOT use retired	during most of wo	rking	16b. Kind of Bu	siness/Indu	itry
omp	Elementery/Secondary (0-12		(1-4or 5+)	nknow		,		uni	known	
d other avant, t	17. Father's Neme (First, Midd	de, Last)	nknown			18. Mother's Na	me (First, Middl	e, Maiden Sumam		
To de	unknown						known		0	. 4.3
7 is m traum	19a. Informent's Name/Reletic	onship (Type, Print)			Penn Sti			ber, City or Town, MD 2120	117675	ode)
Department of hear any injury or other once.	20e. Method of Disposition  1 Buriel 2 Crematic  4 Donetion 5 🖔 Other		COM	e of Dispos	sition (Name of eatory or other plea		Date	20c. Location -		n, State
ding physician and see as the bunal-transit use as the bunal-transit use when the bunal-transit use as the bunal-transit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	a. Hypt  c  d	Due to (or as	s a consequ	uence of):	IC Can	diovascu d by h	lar dise	ase i	
80 5		littiona contributing to	teath but not resulting	na in the un	derlying cause giv	en in Pert I	23b. Die	tobacco use cor	atribute to ti	he cause of de
d for	Pert II. Other algnificant cond				conjung access give			Yes 22(No	3 Probai	
ned by the atte e detached for y Physicia	Pert II. Other algnificant cond					7.		, 100 2/2/10		bly 4 Unk
as been signed by the attending 2.2 should be detached for use a. npleted by Physician/Manneted by Physician Physici	Pert II. Other algnificant cond							s an eutopsy formed?	24b. Were	autopsy findinable prior to
page 2 shoul							1/D	s an europsy formed?	24b. Were availa comp of de	autopsy findir able prior to detion of cause
certificate has been rector, page 2 should Be Complete	25. Wes case referred to mediexaminer?	ical Hospital	Innatiant 2∏ 50	Westmation	3TI DOA Oth	er	per 1,0 eth (Check only	s an eutopsy lormed? [Yes 2 No	24b. Were avail comp of de	autopsy findir able prior to eletion of cause ath?
irector. After this certificate has been in by the funeral director, page 2 should by the funeral director. To Be Complete rtification: To Be Complete.	25. Wes case referred to mediexaminer?  ***Noves 2  No  27. Menner of Deeth  1  Netural 5  Pen  2  Accident inve  3  Suicide 6  Cou  4  Homicide dete	Hospitel:  Hospitel:  28a. Determined  28a. Determined  28a. Plectouile  27  28a. Plectouile  Plying Physician: To the lat Examiner: On the	e of Injury - At homeling, etc. (Specify)  PCSIAt  be best of my knowle	Bb. Time of Injury  In	28c. Injur Wor M 1 1	er: 4 Nursing I y at k? Yes 2 No	eth (Check only) Home XX Re:  28d. Describe Subject to location City or T.  Baltima.  a, and due to the	s an eutopsy formed?  [Yes 2 No one]  sidence 6 Other how injury occurry nad pro- environments for and numb own, Stete and Numb own, Stete and nad one C 'ty, e cause(s) and ma	24b. Were available of de 1,200 of de 1,20	e autopsy findir able prior to able prior to seltion of cause ath?  Yes 2 No  Expessur  Emperatu  Gy fan Divi  Yiand  ed.
iter cearn.  Inector: After this certificate has been in by the funeral director, page 2 should the funeral director. To Be Complete.	25. Wes case referred to mediexaminer?  **XXYes 2 No  27. Menner ol Deeth  1 Netural 5 Pen  2 Accident  3 Suicide 6 Cou  4 Homicide 6 Col  29a. Certifier 1 Certifi	Hospitel: 1 28a. Determined 28a. Determined 2.7.7 28e. Piecbuik	of Injury nth. Day Year) INC  e of Injury - At home ling, etc. (Specify)  PCSIAL  e best of my knowle	Bb. Time of Injury  In	28c. Injur Wor M 1 1	er: 4□ Nursing I  y at k?  Yes 2⊠No  ne, date and place pinlon, death occ	eth (Check only) Home XX Re:  28d. Describe Subject to location City or T.  Baltima.  a, and due to the	s an eutopsy formed?  [Yes 2 No one]  sidence 6 Other how injury occurry nad pro- environments for and numb own, Stete and Numb own, Stete and nad one C 'ty, e cause(s) and ma	24b. Were available of de 1,200 per (Specify) red entel to ror Rural F Washin Man and due to the stand due to the salar and due to the	e autopsy findinable prior to lelion of cause ath?  Yes 2 No  Exposure  Emperial under prior to level to lelion of cause ath?
for the form of the control of the c	25. Wes case referred to mediexaminer?  **Notes** 2	Hospitel:    Hospitel:	of Injury  ith Day Year)  Apple 19 19 19 19 19 19 19 19 19 19 19 19 19	bb. Time of Injury  In I	28c. Injur Wor 1   28c. Injur Wo	er: 4□ Nursing I  y at k?  Yes 2⊠No  ne, date and place pinlon, death occ	eth (Check only) Home XX Re:  28d. Describe Subject to location City or T.  Baltima.  a, and due to the	s an eutopsy formed?  [Yes 2 No one]  sidence 6 Other had pre- environments, Street and Numb own, Stele) 802 ore City, e cause(s) and ma h, date and place, a	24b. Were available of de 1,200 per (Specify) red entel to ror Rural F Washin Man and due to the stand due to the salar and due to the	e autopsy findinable prior to able prior to autopa finding fin

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#7,8 perFH G780 2/24/2000 EW 1. Decedent's Name (First, Middle, Last) 2 Date of Death Ebruary 18, 2000 Addie Mozell Yancey 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Hmore

Days

21223

If Under 24 Hrs.

45

10d. Inside City Limits 1 No 2 No

Interval Between Onset and Death

8. Date of Birth (Month, Day, Year) 1914 9. Birthplece (State or Foreign Country)

July 6, 1913

USA

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

Hospital

Oxford, NC.

18. Mother's Name (First, Middle, Maiden Sumeme)

102/24

Cora Tuck

14. Raca - American Indian, Black, White, etc.

Black

**Director** with the Maryland r 28a-f ahow 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be r Pages 1 and 2 should be filed within 72 hours aftar death value of Heelth end Mental Hygiena.
Int: If Item 27 ia marked other than "natural", or Items 23.

**Physician** 

/Medical

Examiner

Important: If it any injury or c once. **Physician** /Medical Examiner

physicien end the burial-transit 88 usa signed by the e been sig certificate has b lirector, pege 2 si Be 2 this funeral Certification: After

Box 68760. Division of Vital Records. Attending death. after death filled in by 6 24 hours Hospitai To the Hosp within 24 hos To the Fune completely fi

General Maryland
5. Social Security Number if Under 1 Year **Funeral** 1□M 28F Vrs. 238-52-9225 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Directo MD. Raltimore 10f. Zip Code 10e. Street and Number Funeral 501 West Franklin Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Housekeeping 8 17. Father's Name (First, Middle, Last) Be 2 Nelson Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Mae Wilkinson-Step-Daughter 8517 Dick Blackwell Rd. Oxford, NC. 27565

20a. Method of Disposition Name of cemetery, crematory or other place)

1 Provided a Company of the Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowview Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. decell 736 Edmondson Ave. Baltimore, Md. 21228 enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner toRe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Physician/Medical p Completed

ess of person who completed cause of death (Item 23a) (Type, Print)

1-ar lure Due to (or as a consequence of) 23b. Did tobacco uss contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Michknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 00

Registrar

edical

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death Yea Gilma Dale Anderson FEBRUARY 9 2000 17:23 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days 15M 20 F Yrs. 233-20-3553 8/08/21 VIRGINIA Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits WV 1€Yes 2 No Mineral Keyser 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 196 B Street 26726 USA Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 Tyes 2 No If Yes, Give Yeer or Detes: WWII 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Railroad 12th Railroad Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robey Anderson Prudy L. Parks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 196 B Street, Keyser, WV 26726 Eleanor Anderson - wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Potomac MemorialGardens 2/12/00 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility old MARKWOOD FUNERAL HOME, INC. 23e. Pert1. Enter the disease, or complications that/ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. shock, or heert failure. List only one ceuse on each line. nllo WV 26726 Approximete Interval Between Onset and Death Immediate Ceuse (Finel diseese or condition resulting in deeth) SEVERE CARDIOMYOPATHY 6 MONTHS Due to (or es e consequence of): b. ISCHEMIC HEART DISEASE 2 YEARS Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown LUPUS NEPHRITIS, CHRONIC RENAL FAILURE, METASTASIS 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy CARCINOMA OF FACE completion of ceuse of death? 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) examiner?

1 Yes 2 No

27. Manner of Deeth

1 Neturel

2 Accident Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

physician and s the burial-transit that the death certificate be axecuted GILMA ANDERSON 233-20-3553 5 signed b Division of Vital Records, page 2 s certificata

Examiner Physician/Medical à Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Herns 23a

"natural", or

Hygiene.

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 Is merked oth any Injury or other treumetic even page.

**Physician** /Medical

Examiner

death 1

filed within 72 hours after

Baltimore, Maryland 21215-0020

the Medical Examiner must be nothing at

Director

Funera

P

Completed

Be

Completed

edical Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification that the funeral director, completely filled in by the funeral director, 10

DR. N.A. 31. Dete filed (Month, Dey, Year) State Registrar

4 Homicide

29b. Signeture and title of certifier

RANJITHAN,

29e. Certifier (Check only one)

Kan 30. Name end address of person who completed cause of death (flem 23a) (Type, Print)

517 OLDTOWN ROAD, 32. Registrer's Signeture



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

D 19318

29d. Date signed (Month, Day, Year)

FEBRUARY //

2000

FEB 1 4 2000

General De Sypholic

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## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** GERTRUDE VIRGINIA BRODE February 12, 2000 00:57 A.M. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 1□M 2XF Months Yrs. 218 16 3547 Director 82 JAN 3 1918 MARYLAND Usuei Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND ALLEGANY FROSTBURG Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 254 CENTENNIAL STREET 21532 U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give ъ altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE p 3XXWidowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME pormit. Pagas 1 and 2 should be fit.
Department of Health and Mental Hit Important: If fear 27 is marked oth any Injury or other 11s. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be JAMES SMITH 2 HELEN LAVIN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HILARY BRODE, JR./SON 119 N. FLOYD ST., ALEXANDRIA, VA 22304 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2/15/00 CUMBERLAND, MD SUNSET MEMORIAL PARK 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. Durch 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Vulumy desease /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as e consequence ot) usa as attending 0 ed by the a P.O. | Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach Unknown 1 ☐ Yee 2 ☐ No 3 Probably Division of Vital Records. þ Completed 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of deeth? has 1 ☐ Yes 2 ☐ No mis certificate director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 2 ER/Outpatient 3 DOA 1 Nopatient 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Affair Attending 5 Pending investigation Naturat death. 1 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, term, atreet, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours at To the Funeral Di edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) manner stated. 29b. Signature a 29d. Date signed (Month, Dey, Year) **February** 2000 NOE 30. Name and addr m 23a) (Type, Pri 5 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

Registrar

FEB 1 5 2000

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Feb 13, 2000 Virgil Buskirk 12:55pm /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14300 Jared Drive Lot Y Pinto Allegany If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 8, 1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1QM 2□F MD 72 212-24-0341 Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Allegany Pinto 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 14300 Jared Drive Lot Y 21556 USA Funerai 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Textile Retired Supervisor 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event other and Injury or other treumatic avent other. Be John Buskirk (McKee) Marian 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Kim Ritchie P.O. Box 5084; Cresaptown, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Duriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Rocky Gap Veterans Cem2/17/ Flintstone, MD 21. Signature of Funeral S. 22Scarperil Funeral Home P.A. Cumberland, Maryland 23e. Part1. Enter the disease, or some actions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line Approximeta Interval Between Onset and Death **Physician** /Medical tmmediete Cause (Final disease or condition resulting in deeth) Arteriosclerotic Heart Disease unknown yrs Examiner Due to (or as a consequence of): Examiner physicien end the burial-transit Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last certificate be execu Due to (or as e consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 980 P.O. Pert tt. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The lew page 2 s has 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medicat examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 Other (Specify) After this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred al or Attending P Division 5 Pending investigation Neturet Injury 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral C Hospital edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of castifier 29c. License number 29d. Date signed (Month, Day, Year) NOB D09157 February 13, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D.; 124 W. Third Street; Cumberland, MD 21502 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State Registrar FEB 1 4 2000

FEB 1 & 2000 Source 15

## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Depa

irtment of Health and Mei	ntal Hygiene	0	-	0	0	0
irtment of Health and Mei tificate of Death	Reg. No.	0	0	U	O	l,

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Catherine

Bennett Anna

2 Dete of Death 2000 Year Feb 9,

3. Time of Death 08:18pm

4a Fecility Neme (If not institution, give street and number)

4b. City, Town, or Location of Deeth Cumberland

4c. County of Deeth Allegany

**Funeral** Director

the Maryland tem 27 is marked other than "natural", or flems 23a or 28a-1 show other traumatic event, the Modical Examiner marke notified at Directo with t death y Funeral 72 hours after by Completed filed within 7 I Hygiena. permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Allegany County Nursing Home 1□M 20 F 214-07-4755

Allegany

7. Age (In yrs. last birthday) 85 Yrs

10c. City, Town or Location

| If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Nov 11, 1914 9. Birthplece (State or Foreign MID

> 10d. Inside City Limits Yes 2 No

10e. Street and Number

10e. Stete

MD

Cumberland 10f. Zip Code

10g. Citizen of What Country?

Usuel Residence of Decedent

10b. County

135 N. Mechanic Street

21502

USA 14. Rece - American Indian. Black, White, etc.

1 Never Married 2 Married X□ Widowed 4 □ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 E No If Yes, Give Yeer or Detes:

 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes X ☐ No Specify:

Specify white 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker

Own Home

17. Fether's Neme (First, Middle, Last)

Charles Parrish

18. Mother's Neme (First, Middle, Maiden Sumeme)

(Harden) Susie

19a. Informant's Name/Reletionship (Type, Print)
Sue C. Bittner

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
14108 Bald Knob RdNW; Mt. Savage, MD 21545 Dete 20c. Location - City or Town, Stete

daughter

1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place)

Luke's Lutheran Ce2/12/ Cumberland, MD

Scarberrio Funeral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only the cause on each line.

St.

**Physician** /Medical Examiner

and

ettending physician for use as the buria

detached

been signed by should be detacl

After this certificate has

funeral

filled in by

that the deeth certificate be axecuted

The law requiras

Physicien:

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Box 68760,

P.O.

Division of Vital Records,

Examiner

Physician/Medicai

þ

Completed

Be

P

Certification:

Medical

Immediate Cause (Finel disease or condition resulting in death)

nce of):

Approximete Intervel Between Onset and Deeth

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequi cm exs Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

1 Yes 2 No 24a. Wes en eutopsy performed?

3 Probably 4 Unknown

23b. Did tobacco use contribute to the cause of death?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

26. Plece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel exeminer? 20 No 1 Yes

Hospitel: 5 Pending investigation

6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Manner of Death

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signeture end title of cedifier

29c. License number

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and eddress of person wind completed cause of deeth (Item 23a) (Type 31. Date filed (Month, Dey, Year,

FEB 1 4 2000

32. Registrer's

6

NOB

Registrar

75.8 8 5.000 James 15 Aprents

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedenl's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Richard Barnes Ernest 6:51PM FD b 2000 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOWAR Deneral HOSPITAL DUMBIA HOWARD COUN if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year)
Feb 10 2000 If Under 1 5. Sociei Security Number 7. Aga (In yrs. last bithday) Birthplece (State or Foreign Country) **Funeral** Months 18 M 2□ F Director n/a Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location r than "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No. Maryland Howard Ellicott City 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 9905 Carrigan Drive 21043 USA Funeral filed within 72 hours efter death 12. Wes Decedenl Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married ☐ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiane. Elementery/Secondery (0-12) College (1-4or 5+) n/a n/a n/a permit. Pages 1 and 2 should be file Department of Haaith and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Douglas Mark Barnes Christine Anne Kaufman Barnes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Douglas M. Barnes/ father 9905 Carrigan Dr. Ellicott City, MD 21043 20e. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ☐ Buriel 2 € Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 2/18 Chester, Maryland 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Between Onsat and Deeth Physician /Medical Immediate Ceuse (Finel Insufficiency diseese or condition rasulting in deeth) **Examiner** Examiner Sepsis The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or Injury that initieled events rasulting in death) Lest pue bunial-tran Due to (or es e consequence of): Box 68760. ettending physiclan Physician/Medical \$ Due to (or as a consequence of): use as P.0. Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the 2000 3 Probably 4 ☐ Unknown 1 Yes Division of Vital Records, þ Completed 24b. Were eutopsy findings aveilable prior to complation of ceusa of deeth? 24e. Wes an autopsy performed? peen this cartificata 1 Yas Hospital or Attanding Physician: director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident aftar death filled in by the 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steled.

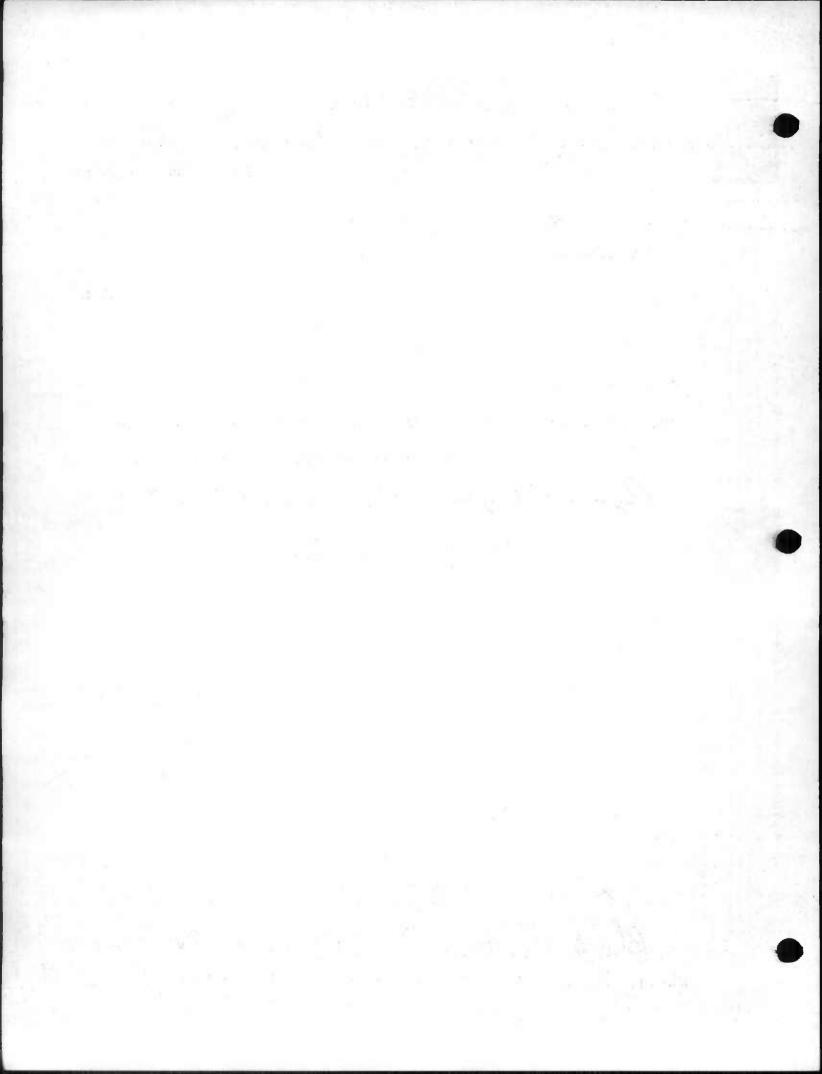
Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical å E 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number FR6 17. 2000 47620 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year) FEB 2 2 2000

Bharti

Razdan, MD 5755 Cedar Day, Year) 32 Registrer's Signature 9. lumbia MD 21044

DHMH 16 Rev 6/95



#### Albert Pres Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Jeffrey Lee Bishop a 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Goldsboro If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 14740 Drapers Mill Rd Caroline 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthdey) 6. Sex Birthplece (Stete or Foreign Country) 1 M 2 □ F Months Deys Yrs. 36 220-78-2394 March 31,1963 | Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Caroline Goldsboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14740 Drapers Mill Rd 21636 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 grain farmer agriculture 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Richard David Bishop Sr Marjorie Myers 19a. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14725 Drapers Mill Rd Marjorie Bishop / mother Goldsboro, Maryland 20a. Method ot Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Remove from State 4 ☐ Donetion 5 ☐ Other (Specify) Greensboro Cemetery 2-17-00 Greensboro, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland shock, or heart teilura. List only one cause on each line. 21639 Approximete Interval Between Onset end Deeth Gunshot Wound To Immediete Cause (Finel diseese or condition resulting in death) INTANTANEOUS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Ware autopsy findings eveileble prior to 24a. Was en eutopsy performed? completion of catre 2 NO 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one)

The law requires that the deeth certificate be executed pue physician e s the bunalthe attending p signed by the a d be deteched t should t cate hes t certificate

Box 68760,

Records, P.O.

Division of Vital

**Physician** 

/Medical **Examiner** 

**Physician** 

/Medical

Examiner

Funerai

Director

28a-f show

Director

Funeral

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Completed

Be

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Exeminations.

Baltimore, Maryland 21215-0020

the Marylend

deeth

Examiner Physician/Medical by Completed To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 2 Certification:

Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case reterred to medical exeminer?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 4 ☐ Homicida 6 Could not be determined 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier ne ot certitier

State Registrar

Medical

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31. Dete tiled (Month, Day, Year) FEB 1 6 2000

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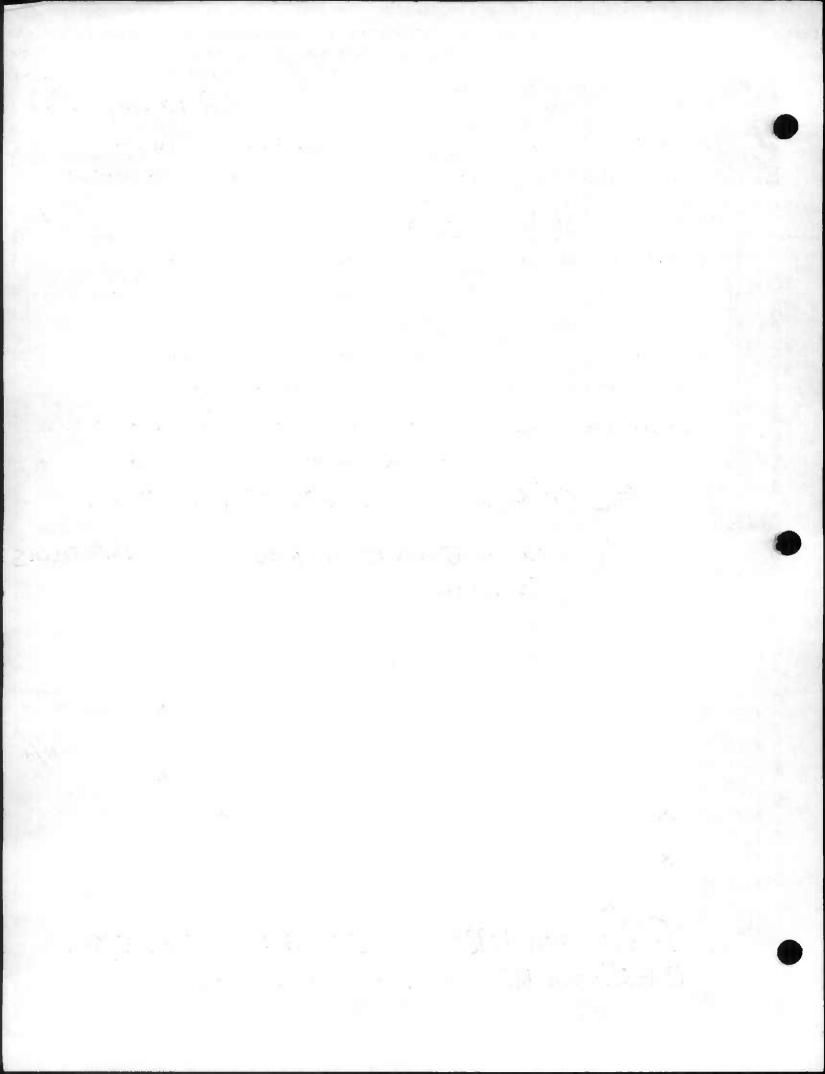
PO Box 690 32. Registrer's Signeture

ot death (Item 23e) (Type, Print)

Denton, Maryland

29d. Date signed (Month, Day, Year)

21629



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Division of	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi 
Divi	after of Direct of in by
	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the f
	the H hin 24 the Fu
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Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Year **Physician** BARBARA DAPHNE CARPENTER February 11, 2000 2:53 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Allegany Cumberland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 F 75 WEST **VIRGINIA** Director MAR. 23,1924 219-14-6927 **Usual Residence of Decedent** The Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No MD ALLEGANY LAVALE Director 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 11921 CASH VALLEY ROAD, NW 21502 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, Whita, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: WHITE ğ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 about be fin transit of Health and Mental H fant: If hem 27 is marked oth dury or other traumatic even 88 THOMAS R. CROYLE GRACE IRENE THOMPSON 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HOWARD W. CARPENTER, JR. / SON 11921 CASH VALLEY RD, NW, CUMBERLAND, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or RESILAWN MEMORIAL GARDENS 2/13/00 4 ☐ Donation 5 ☐ Other (Specify) LAVALE, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facilit UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLNAD, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease 10 years Examiner Due to (or as a consequence of) Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es a consequence of). physician the buria 68760 Physician/Medical Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? peed certificata has page 2 The 1 Yes 2 No 1 ☐ Yas 2 ☐ No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of 1 Netural 5 Pending investigation 1 Tyes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tile of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2000 D0033280 February 625 Kent Avenue, Suite 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunil Gupta, Johnson Heights Medical Building, 21502 Cumberland, MD 32. Registrar's Signature EB ite 2000 Registrar

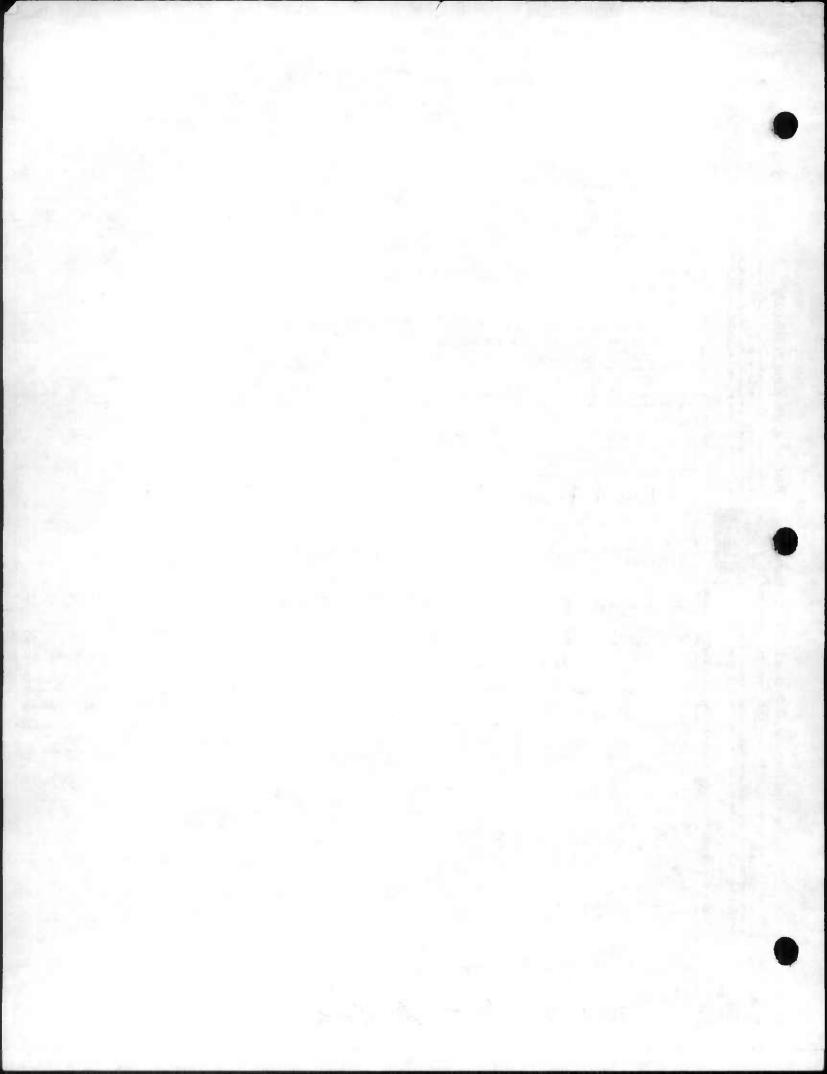
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State of Manyland / Donartment of Healt	th and Montal Hygiona

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18,2000 Feb. **Physician** Gladys M. Chambers 0457 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan.9,1914 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F 222-03-7096 86 Yrs. Director Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or Items 23s or 25s-1 show Caroline MD Federalsburg 1X Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Liberty Road 21632 United States Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yas 2 No 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specity: White Specify: à 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sportswear Seamstress 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nent of Health and Mental Charles S. Meredith Lillie M. Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If them 27 is n Gary M. Chambers/Son 6959 Reliance Rd., Federalsburg, MD 21632 altimore, 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Hill Crest Cemetery 12/22 Federalsburg, MD 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** eart Failure /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner ertenglor Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pug Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or es e consequenca of): d for use as t signed by the et d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 Yes 2 XNo 1 ☐ Yes 2 No funeral director. 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 papatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No After this 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Netural 24 hours after death.

Funerel Director: A 1 Yes 2 No 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier 15 certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred et the time, date end place, and due to the cause(s) and manner steted. 29b. Signeture and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 920 James 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 2 2 2000 maria Registrar



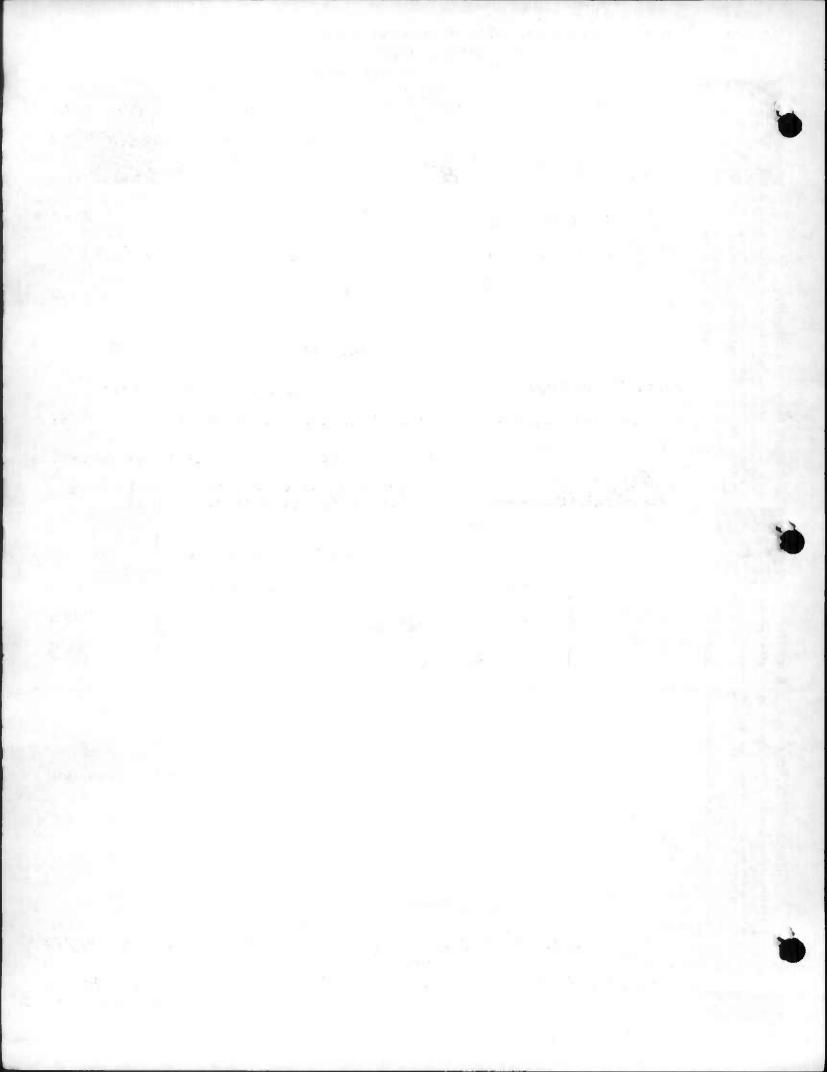
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middla, Lass)  4a. Facility Nema (If not institution, give GLAS GOW)  5. Social Security Number  6. Security Number  10a. State  10b. County  10c. Street and Number  31 GLENBUR  11. Merital Status  1 Navar Marriad 2 Married  3 Widowed 4 Divorced  15. Decedent's Edementary/Secondary (0-12)  12  17. Fathar's Name (First, Middla, Last)  Harry F. White  19a. Informant's Name/Reletionship (TRev. William P	a street end number)  NURSING  AND  AND  AND  AND  AND  AND  AND  A	GHOYY (In yrs. last birth  97  10c. City, Town  C F  arr in U,S.	or Location  MBR / DG  10f. Zip Code  13. Was Decedant of I If Yes, specify Cub  1	Hours Min.  E  I 6 1 3  Hispanic Origin? (Span, Mexican, Puarto	idge 8. Data of Bir Month, Da 01-2.	Day  1  4c. County  DO  6  1  7  7  7  1  1  1  1  1  1  1  1  1	9. Birthplace (Stata or Fore Country) Maryland  10d. Inside City Lim  1 X Yes 2	
5. Social Security Number  219-05-0696  Usuai Residence of Decedent  10a. State  10b. County  10e. Street and Number  311 GLENBUR  11. Merital Status  1 Navar Marriad  15. Decedent's Edi (Specify only highest grace  Elemantary/Secondary (0-12)  12  17. Father's Name (First, Middla, Last)  Harry F. White  19a. Informant's Name/Reletionship (7)  Rev. William P	a street end number)  NURSING  A 2 F  7. Aga  7. Aga  12. Was Decedant E. Armed Forcas? 1 Yas 20 No. If Yas, Give Yeer or Datas:  Jucation da completed)  College (1-4or 5+	GHOYY (In yrs. last birth  97  10c. City, Town  C F  arr in U,S.	or Location  MBR / DG  10f. Zip Code  13. Was Decedant of I If Yes, specify Cub  1	Cambr If Undar 24 Hrs. Hours Min.  E  Lo 13 Hispanic Origin? (Span, Mexican, Puarto	idge 8. Data of Bir Month, Da 01-2.	DOR by, Year) 5-913	9. Birthplace (Stata or Fore Country)  Maryland  10d. Insida City Lim  12(Yas 2 1)  What Country?  S. A.	
5. Social Security Number  219-05-0696  Usuai Residence of Decedent  10a. State  10b. County  10e. Street and Number  311 GLENBUR  11. Merital Status  1 Navar Marriad  15. Decedent's Edi (Specify only highest grace  Elemantary/Secondary (0-12)  12  17. Father's Name (First, Middla, Last)  Harry F. White  19a. Informant's Name/Reletionship (7)  Rev. William P	TESTER  12. Was Decedent E. Armed Forcas? 1   Yas   20   No. If Yas, Give Yeer or Datas:  Jucation da completed)  College (1-4or 5+)	(In yrs. last birth  87  10c. City, Town  C F  var in U.S.	or Location  Months Days  or Location  10f. Zip Code  13. Was Decedant of I If Yes, specify Cub  1 Vas 2 No	Cambr If Undar 24 Hrs. Hours Min.  E  Lo 13 Hispanic Origin? (Span, Mexican, Puarto	idge 8. Data of Bir Month, Da 01-2.	DOR by, Year) 5-913	9. Birthplace (Stata or Fore Country)  Maryland  10d. Insida City Lim  12 Yas 2 1	
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avaminar?	Hospital:	2□ ER/Out	patient 3 DOA Oth	AOL.			at (Specify)	
27. Manner of Death								
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29b. Signatura end titla of certifiar	ario mannar state		29c. Licans	sa number		29d. Data signed	d (Month, Day, Year)	
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30. Name and address of nerson who or	Curbinten nansa ni nga	III (III EJUL)	Who Print					
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Registrar

FEB 1 5 2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Floyd Daniel Duckworth February 09, 2000 3:12 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10039 Piney Mountain Road Allegany Eckhart If Under 1 Year | If Unda 5. Social Security Number If Undar 24 Hrs 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F Yrs. 216-30-1734 67 Director 24-Aug-32 Maryland Usual Rasidence of Decedan the Maryland 10s. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. tnside City Limits 1 Yas 2 No Director Maryland Aliegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10039 Piney Mountain Road 14. Race - American Indian, Funeral 21532death 12. Was Decedent Evar in U.S. Armed Forcas? 1 2 yas 2 □ No If tras, Giva Yaer or Detes: Kovea M 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status fict 72 hours efter 1 Never Married 2 Married COK Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry ified within 7 Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth end Mental Physient Important: if tem 27 is marked other than eny injury or other traumatic event, that page. driver 11 manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be **Dewey Duckworth** Martha Jewell 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Nancy Duckworth Wife 10039 Piney Mountain Road Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 4 Donetion 5 □ Other (Specify) Frostburg Memorial Park 11-Feb-00 Frostburg, Maryland 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Zu 23a. Part. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximeta Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseasa or condition rasulting in death) Examiner Examiner areurys dortic physicien and s the burial-transit certificate be executed Sequantielly list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaase or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): the scleary Box 68760 Physician/Medicai Dua to (or as e consequance of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? P.O. the signed by to d be detech Nes 2 No 3 Probably 4 Unknown Chanic Division of Vital Records. 2 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 1 Yas 2 Davio 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case rafarrad to medical exeminer? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 10 1 Yas 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 5 Panding investigation 1 Tas 2 No 2 Accident 6 Could not be 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 T Homicida

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29e. Cartifiar

(Check only one)

29b. Signature and title of certifie

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Dr. Thomas J. Deviin, 200 Douglas Ave., Lonaconing, Maryland 21539

31. Data filed (Month, Day, Year) FEB 1 5 2000 32. Registrar's Signatura

塔 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21488

29d. Date signed (Month, Day, Year)

12-00

Registrar

Floyd Daniel Duckworth February 09, 2000 3:12 FM Allegany 10037 Paney Mountain Road Eckhort 216-30-1/34 24-Aug-32 Maryland Allegany Maryland frostburg 10039 Pinev Mountain Road U.S.A. ShrW diver me doctron Dewey Duckworth Martha Jewell Nancy Duckworth 10039 Piney Mountain Food Hostburg Matyland 21532-----Frostburn Memoral Park. 11-Feb-00 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Homas J. Devlin. 200 Dauglas Ave., Lanaconing. Maryland. 21539

FEB 1 6 2000 James James James 1834

# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Year Month **Physician** VERONICA KATHLEEN DELANEY FEBRUARY 9 2000 12:30 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2QF MARYLAND Yes 218 34 4443 Director Usual Residence of Decedent with the Mandand 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1√ Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18 FROST VILLAGE 21532 U.S. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: Aq. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other th any Injury or other traumatic event, the page. HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 9 NELLIE MAY KLOSTERMAN ROBERT W. SHUCK 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY KAY BEACHY/DAUGHTER P. O. BOX 191, GRANTSVILLE, MD 21536 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 2/12/00 FROSTBURG, MD ST. MICHAEL'S CEMETERY 4 ☐ Donelion 5 ☐ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 me first caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, use on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediete Causa (Finel 24hours Syndrome Jersi's diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner premoria that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and burial-tran VDue to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical Due to (or as a consequence of) USB AS Carebrovascular Accident; Respiratory Failure a itistory 0 0 ert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contributa to the cause of death? à 1 Yaa 2 No 3 Probably 4 No Nonknown acut Decompensated Conjustice Hemit signed t þ 24b. Wera autopsy findings aveilable prior to completion of cause of death? Dehydration; Coronary 24a. Was an autopsy Completed Chronic obstructive buy D' sear 1 Yas
26. Mace of Death (Check only one) artery Disease 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifica 25. Wes case referred to medical Be axaminer? Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1- Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number FEBRUARY ( 0 2000 NOB ce 021244 30. Neme end address of person who completed cause of death (item 23a) (Type, Print) Frostburg Plaza, Frostburg, MD 21532 esus Ian. 31. Dele filed (Month, Day, Year) 32. Registrar'a Signature

DHMH 16 Ray 6/95

Registrar

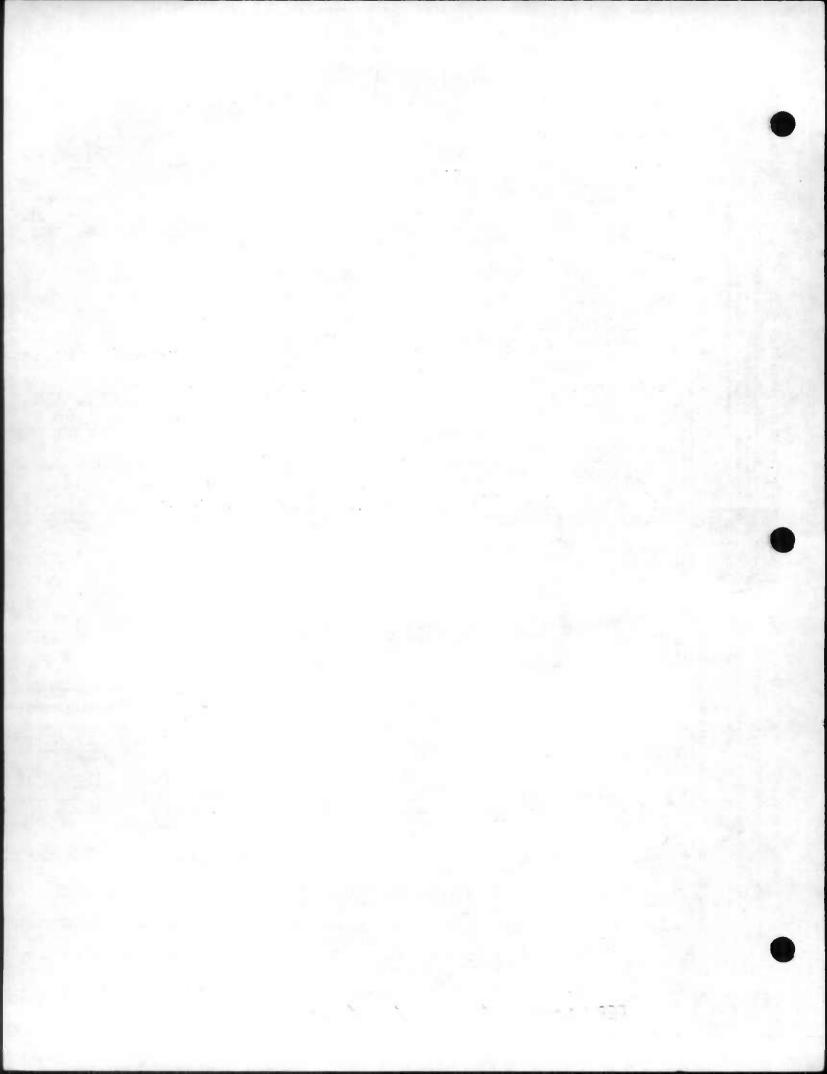
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

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	Examin	er	Sacred			rtturrioery				Cumberla				
	Funeral Director		5. Social Security P	2371	6. Sex 1 <b>X</b> M 2		a (In yrs. las	st birthday) Yrs.	If Under 1 Yaer Months Days	If Under 24 Hrs. Hours Min.	8. Deta of Bir (Month, De May 9,	<sup>th</sup> 1916	9. Birthp Coun Mary	laca (State or Foreign (IV) Tand
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Year Month BERNICE LOUISE ERICKSON 9 FEBRUARY 2000 18:00 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND Birthpleca (State or Foreign Country) 8. Dete of Birth (Month, Day, APRIL 9 If Under 1 Ye 5. Sociel Security Number 7. Age (In yrs. last birthday) 1□M 2XF Months Hours W.VA. 88 214-07-6947 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits CUMBERLAND 1 Yes 2 □ No MARYLAND ALLEGANY 10e Street and Number 10f Zin Code 10g. Citizen of Whet Country? U.S.A. 21502 145 POLK STREET 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus ☐ Yes 2 🖾 No f Yes, Give 1 Never Merried 2 Merried WHITE 1 Yes 2 No Specity: Specify: 3 ☐ Widowed 4 ♥ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10 CELANESE CORP OF AMERICA SILK MANUF. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ELIZABETH G. HOTT CHARLES GARVER PAUGH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 813 COLUMBIA AVENUE CUMBERLAND MARYLAND 21502 RITA ANN LANHAM 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) REST LAWN CEMETERY FEB 12 2000 AVALE MARYLAND 22 Name and Address of Fecility 21 Signature of Funeral Service Lie MERRITT-ADAMS FUNERAL HOME P.A. o 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 24 hours . Cardiogenic Shock diseese or condition resulting in death) Due to (or as a consequence of): Myocardial Infarction 4 days Due to (or as a consequence of): Due to (or as e consequence of)

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other trainers. **Physician** /Medical Examiner

the burial-transit

for use as

signed by the a

and

physician

The law requires that the death certificate be executed

or Attending Physician:

BERNICE ERICKSON 214-07-6947 Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. Stete

**Funeral** 

Director

28a-f ahow must be notified at

ò death with

or Items 23a

Director

Funeral

Completed by

Be

the Maryland

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last edical

Part II. Other significant conditions of	entributing to death but not re-	sulting in the underlying	cause given in Part I.	23b. Did tobecco use c	ontribute to the cause of death?				
				1 ☐ Yes 2 ☒ No	3 Probably 4 Unknown				
				24e. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
				1 ☐ Yes 2 No	1 Yes 2 No				
25. Wes case referred to medical examiner?	26. Place of Death (Check only one)								
1 ☐ Yes 25 No	Hospitel: 1 Inpalient 2	ER/Oulpatient 3 1	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ O	ther (Specify)				
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3 Suicide 6 Could not be determined	28e. Pleca of Injury - At the building, etc. (Special Control of the building) and the building of the buildin	nome, ferm, street, fectify)	28f. Location (Street end Num City or Town, Stete)	ber or Rurel Route Number,					
				ce, and due to the cause(s) end no curred at the time, date end plece					
29b. Signeture end title of certifier			9c. License number	29d. Dete sign	ed (Month, Dey, Year)				

To the Hospital or Attand within 24 hours after deat To the Funeral Director: filled in by npletely 3

DR. WILLIAM LAMM, 47 31. Dete filed (Month, Dey, Year) FEB 14

VIRGINIA AVE., 32. Registrar's Signeture

ten my

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

CUMBERLAND, MD

D 25406

FEBRUARY

21502

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth **Physician** Month 11:30 02 EGGERS 11 2000 /Medical 4a. Facility Neme (If not Institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** GENEVAL DORCHESTER HOSPITAL CAMBO DEE Derchester 5. Social Sacurity Number If Undar 1 Yaar | if Under 24 Hrs. 6. Sax 6. Date of Birth (Month, Day, Year) HDY)L 1, 1925 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 246-22-5378 Deys 1 M 2□ F Yrs Director TENN Usual Residence of Decedent the Meryland 10c. City, Town or Location 10e State 10b. County 10d. tnside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No CAROLINE Director FED EY ALS BURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CHAMBERS 21632 USA STYCET death Funeral 12. Was Decedent Ever in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours effer c Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "natural", or flen any Injury or other traumatic axant 18 Yes 2 No If Yes, Give Yaer or Dates: 1945-46 1 Never Married 22 Marriad Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MAINTANCE GENEVAL MAINT. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) MUGLAMERY

Chata Zlo Code) 21632 CHAYLES MAY EEGERS TITA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAYGATET EBORG-WIFE 114 CHAMBERS EDETALSBUTE, MD 20b. Place of Disposition (Name of cemetery, crametory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 DeBurial 2 Crametion 3 Removal from State DULANCYVALLEY 4 Donetion 5 Other (Specify) 021 00 TIMONIUM, MD 21. Signature of Funerel Service Licensee FEDERALSBUYE. MD 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on aach line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) Minutes Examiner nding physician and use es the burial-transit Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaese or Injury that initiated events resulting to deeth) Last P.O. Box 68760 death certificete be Physician/Medical Dua to (or as e consequence of) ò signed by the et d be deteched for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Division of Vital Records, py 24e. Wes an autopsy performed? 24b. Were autopsy findings avellable prior to completion of cause of deeth? Completed peen has 2 1 No 20 No certificate 1 ☐ Yes Attending Physician: 25. Wes case referred to medical examiner? 28. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Dinpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Medical Certification: After 1 Neturel 5 Pending investigetion To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 112 Certifying Phyaiclan: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.
2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and mannar stated. 29e. Certifier 29b. Signature and title of certifian 29c. Licensa number 29d. Date signed (Month, Pey, Year)

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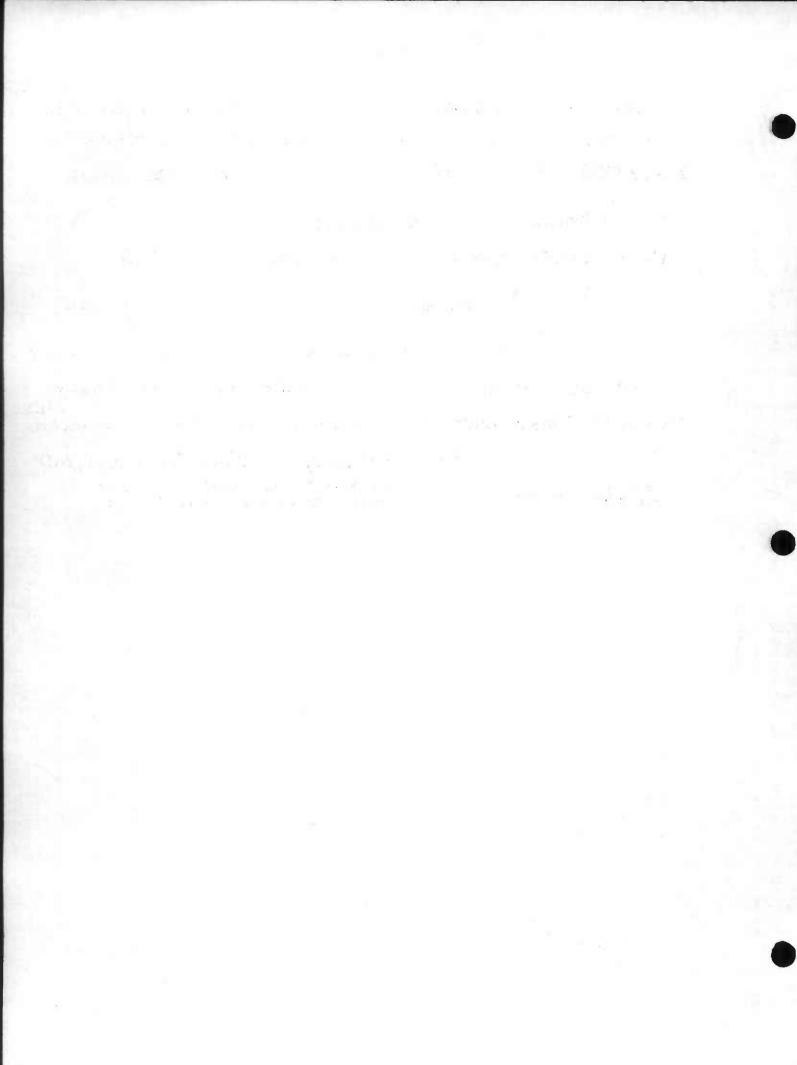
State Registrar ess of person wh

31. Dete filed (Month, Dey, Year) FEB 2 2 2000 completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

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bridge.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death **Physician** Feb. 10°, 2000° 0342 Theodore Eiswald Fletcher, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital Easton Talbot Easton If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1♥ M 2□ F 216-14-9148 80 Yrs. Director Oct.21.1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. fnside City Limits show 1 Yes 2 □ No MD Caroline Directo Preston 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 137 Main Street 21655 United States Funeral or Berns 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, etc. 1) Yes 2 No If Yes, Give Yaar or Datas: WW II 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Canned Foods Broker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 2 should be fi and Mental h Be Ola Moore Theodore E. Fletcher, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: if Item 27 is m any injury or other traum Helen S. Fletcher/Spouse P.O. Box 186, Preston, MD 21655 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Removal from State Junior Order Cemetery 2/13 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Ho PO Box 43, Federalsburg, MD 21632 Home, PA +. Eskew 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Cardionna las dispase /Medical Immediate Causa (Final disease or condition resulting in death) Examiner to (or as a consequence of) Examiner the burial-transit and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): USe as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yee 2 No 3 Probably 4 Ponknown þ Completed 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate funeral director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyetofan: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Data filed (Month, Day, Year) FER 1 4 2000

29b. Signatura and titla of certifier

30. Name and address of pe

Ludwig J.

Egiseder, III, M.D. 32. Registrar's Signature

son who completed pause of death (Item 23a) (Type, Print)

DOLKE

29c. Licensa number

505 Dutchman's Lane,

29d. Date signed (Month/Day, Year)

Easton, MD 21601

Theodore Fletcher

21215-0020

Baltimore, Maryland

Pages 1 and 2 should

The law requires that the death certificate be executed

P.O. Box 68760.

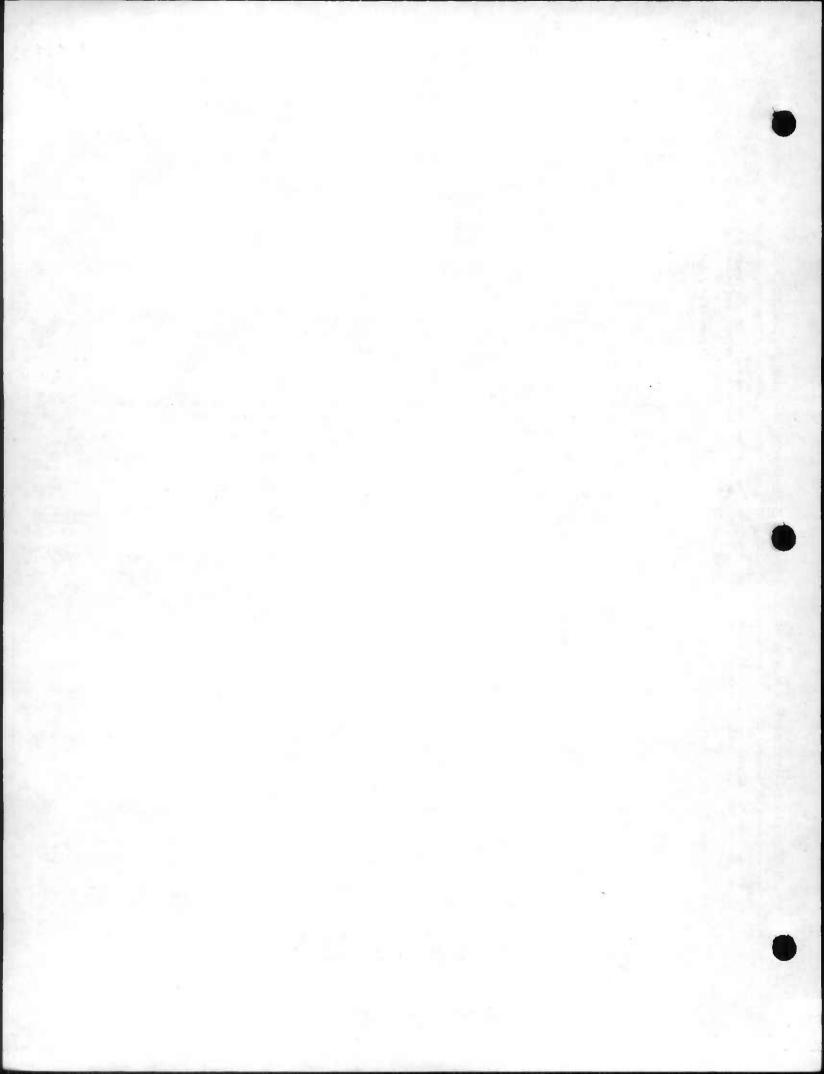
Records,

Division of Vital

Hospital or Attending Physician:

the

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year **Physician** TERESA JANE Feb. 18,2000 3:15 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER; GENESIS ELDERCARE SALISBURY, MD. WICOMICO If Under 1 Yeer Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Months Hours 10 M 20 F Director the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits netural", or items 23s or 28s-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? death with 2183 115A Funeral 12. Was Desident Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give 11 Maritei Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: à 3 ☐ Widowed 4 ☑ Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life! DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Nem 27 le marked other than eny Injury or other traumatic event, the Motes. Elementary/Secondery (0-12) College (1-4or 5+) tome 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be P 19a-Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Woughte renz O 20e. Method of Disposition 20b. Plece of Disposition (Name of Date 20c, Loca 1 Buriel 2 □ Cremetion 3 ☐Removal from State Nemorial 4 ☐ Donation 5 ☐ Other (Specify) bolines 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Willealte tuneral nane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel Ry disease or condition resulting in death) Examiner Due to (or a) Examiner The law requires that the death certificate be asscuted and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 Physician/Medical the Due to (or attending p ata has been signed by the a page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy 2 No certificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physicien: 25. Wes case referred to medical exeminer? funeral director, 26. Place of Deeth (Check only one) Other: Medical Certification: To 1 Yes 2 No 1 Inpatient 4 PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Naturel death. 1 Yes 2 No 2 Accident within 24 hours efter deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 29e. Certifier 1 Confirming Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D-29349 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1104 HEALTHWAY DR. WILLIAM ROBINS, M.D., , SALISBURY, MD 21804 31. Dete tiled (Month, Dey, Year) FEB 2 2 2000 State Registrar

DHMH 16 Rev 6/95

English Di Lareit.

Amended \* 23A. A.G.c interview Allegeny County 2/15/00 MZU

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death brothy H. Junkins Year Physician 0313 AM 10 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Balthore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 235-30-0268 1 M 250F 76 Yrs. Director February 10, 1924 West Va. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Mineral Elk Garden 1 ☐ Yes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Route 1, Box 83 26717 United States Barra 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 72 hours after 1 Yes 2004No If Yes, Give Year or Detes: 1 ☐ Never Merried > Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2XNo Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etamantary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be next of Health and Mental John T. Haines Ida P. Davey 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health a Important: If Item 27 Is any injury or other tra 2008. Russell E. Junkins / Husband Route 1, Box 83, Elk Garden W 26717 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Nethkin Hill Cemetery February 14, 2000 Elk Garden, W 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart faiture. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) 5-Days Examiner Examiner noraco abdominal anewysm 3 Months physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): acute rena Box 68760 5 Days tai Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vitai Records. 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yas 20 No or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Impatient Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Manner of Death 28b. Tima of 28c. tnjury at Work? After 1 Naturat 2 Accident 5 Pending death. Investigation 1 Yes 2 No n 24 hours after death.

• Funeral Director: / 8 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD resident physician as 10 2000 12400 30. Name and address of person who complated cause of death (them 23a) (Type, Print)
Chr3-topher Gannon 22 Sorth Greene Street Bultmore, Mayland 21201 6 31. Dete tiled (Month, Day, Year) 32. Registrar's Signatura State FEB 1 5 2000 100xKn/ Registrar

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Piease Type or Print in Biack indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death FEBRUARY 11 2000 7:55 PM DAVID MILTON JOHNSON 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY 13505 BEDFORD ROAD N.E. CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
JULY 24 1923 NORTH CAROLINA 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Days Hours Months Yrs 76 217-18-4265 **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d, Inside City Limits ALLEGANY CUMBERLAND MARYLAND. 1 Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21502 U.S.A. 13505 BEDFORD ROAD N.E. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Yes 2 No If Yas, Give Year or Datas: 1 Never Married 2KM Married Specify: WHITE 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST 12 A.B.L./McKAIGH 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) ADA BROTEMARKLE JOHN HENRY JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 13505 BEDFORD ROAD N.E. CUMBERLAND MARYLAND 21502 WIFE NAOMI K. JOHNSON 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) FEB 15 2000 CUMBERLAND MARYLAND SUNSET CEMETERY Signature of Funeral Service Line 22. Name and Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. eurl 404 DECATUR STREET CUMBERLAND MARYLAND enter the mode of dying, such as cardiac or respiratory arrest, 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Immediata Cause (Final 9 montes disease or condition resulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760

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Physician

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altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initialed events regulation in devents that initiated events resulting in death) Last

3 Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed?

completion of cause of death?

1 Yas 2√ No 26. Placa of Death (Check only ona)

1 Yas 2 No

25.	Was case examiner?	refarred	d to medical
	1 Yes	2 TN	
27.	Manner of	Death	
	1 XNature	al .	5 Pending

28e. Date of Injury (Month, Day Year) investigation 6 ☐ Could not be

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28d. Dascribe how injury occurred

Other: 4☐ Nursing Homa 5 🖾 Rasidence 6 ☐ Othar (Specify)

29a. Certifier (Check only one)

2 Accident 3 Suicide

4 Homicide

1 Continued Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 warminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number D 36766

29d. Data signed (Month, Day, Year) FEBRUARY 14, 2000

28f. Location (Street and Number or Rural Routa Number, City or Yown, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR VIK POONAI 920 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

State Registrar

10

31. Data filed (Month, Day, Year) FEB 1 4 2000 32. Registrar's Signatura

FEB 1 4 2000 Survey & Survey

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryla	nd / Department of Health and	Mental Hygiene	
		Certificate of Death	Reg. No.	16075
VIRGINIA	JONES		2. Date of Death  Month  Day  Year  TEPDETARY  2.000	3. Time of 0

**Physician** /Medical Examiner

4a Facility Name (If not Institution, giva street and number)

1. Decedant's Nama (First, Middle, Las

MARY

5. Social Security Number

217-18-4486

FEBRUARY 3 2000 4b. City, Town, or Location of Deeth

Death 13:38PM

CARROLL COUNTY GENERAL HOSPITAL

1□ M 25 F

WESTMINSTER

If Under 24 Hrs.

Hours

4c. County of Death CARROLL

**Funeral** Director

7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examinar must be notified at

e filed within 72 hours efter al Hygiene. other than "natural", or its

should be fi

permit. Pages 1 and 2 should be Department of Health and Mental I important: if item 27 is marked oth any injury or other traumers.

Physician /Medical

Examiner

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Division of Vital Records,

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Physician/Medical

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Maryland 21215-0020

Baltimore,

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death

Usual Residence of Decedent 10a. State

10b. County ALLEGANY 10c. City, Town or Location CUMBERLAND

7. Age (In yrs. lest birthday)

78

8. Date of Birth (Month, Dey, Year) JAN 18, 1922 Min.

9. Birthplace (Stete or Foraign MARYLAND

10d. Inside City Limits

1 ☐ Yes 2 No

Director

10e. Street and Number 13505 BRISTOL DRIVE S.W. 10f. Zip Code 21502

If Undar 1 Yaar

Days

Months

10g. Citizen of Whet Country?

U.S.A.

1 Never Married 20 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give 'Yeer or Detes:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 No Specify:

 Race - American Indian, Bleck, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

KAY JEWELERS

SALES PERSON

17. Father's Name (First, Middle, Last)

JAMES DEWEY BUSKIRK

18. Mother's Name (First, Middle, Maiden Sumeme)

ROSE M. ELKINS

19e. Informant's Name/Raietionship (Type, Print)

DAUGHTER 13505 BRISTOL DRIVE S.W. CUMBERLAND, MARYLAND 21502

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

DEBORAH JONES

20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Pieca of Disposition (Name of cametery, cremetory or other place) SUNSET CEMETERY

Deta 20c. Location - City or Town, State

FEB 7 2000 CUMBERLAND, MD

21. Signature of Funeral Servica Lice

22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

ox.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition rasulting in death)

PULMONARY EMBOLIS, CORONARY ARTERY BY PASS SURGERY Due to (or as e consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events rasulting in daath) Last

Due to (or es e consequença of):

Dua to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐XUnknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29e. Certifian

2 Accident

4 Homicide

5 Pending Investigation 28a. Date of Injury (Month, Dey Year)

28b. Time of

1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the ceuse(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of cartifier

6 Could not be determined

29c. Licansa number

29d. Data signed (Month, Dey, Year)

MD

30. Name and address of person who completed ceuse of death (Item 23e) (Typa, Print)

1130 Bultimore Blvd. Westminster, Mc 21157 Barnstein Andrew m0-

31. Dete filed (Month, Day, Year) FEB 1 0 2000

32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95** 

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent'a Nema (First, Middle, Last) 2. Date of Death Month ANNA NARTE As Fecility Name (If not institution, give street and nu Home STEAD MANCE ASSISTED MARTE AWAGU 6, 2000 4c. County of Deeth EB, 4b. City, Town, or Location of Death LIVING FACILITY DENTON ar If Under 24 Hrs. CAROLINE 410 COLONIAL DRIVE If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Deta of Birth (Month, Day, Birthpiece (State or Foreign Country) Deys Hours 1□M 2 F 213-18-4138 Yrs AUG. 31, 1922 MARYLAND Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD. AROLINE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6335 S GANE 21655 WHARF MOAD 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 € No it Yes, Give Yaar or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father'a Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAYMOND MARY WILLIAMSON COX 19b. Mailing Addraes (Street and Number or Rural Boute, Number, City or Town, State, Zip Code) 213 BLOSMING DALE AVENUE FEDERALSBURG, MARYLAND 2/632 19e. Informent'a Neme/Relationship (Type, Print) W. FLUHARTY /NIECE JOYCE 20b. Placa of Disposition (Name of cematary, crematory or other place) MARYLAND VETERANS CEM. OF THE EASTERN SHORE Date 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cramation 3 □ Removei from Steta 4 □ Donetion 5 □ Other (Specify) 22/00 HURLOCK, MD 22. Nama and Address of Facility WILLIAMSON FUNERAL HOME 21. Signature of Funaral Sarvice Licenti 311 S, MAIN STREET FEDERALS BURG, MARYLAND 23a. Pert1. Enter the disease, or complications that catisad the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21632 Approximate intarvel Betw Onsat and Deeth Immediete Cause (Finel disaase or condition resulting in deeth) Due to (or as e consequence of): Dua to (or es e consequence ot): Due to (or es e consequança ot): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en eutopsy performed? 24b. Were autopsy findings available prior to complation of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Assisted

**Physician** /Medical Examiner

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P.O. Box 68760.

Division of Vital Records,

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in deeth) Last Physician/Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa reterred to medical examiner? 1□ Yes 25 No

5 Pending

Investigation

6 Couid not be determined

Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) LIDING 28d. Describe how injury occurred 28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Piece of Injury - At homa, term, street, tactory, office building, etc. (Specify)

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29e. Certifier

27. Manner of Deeth

1 Netural

2 Accidant

4 Homleide

3 Sulcide

Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date and piece, and due to tha cause(s) and manner as stated. 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end mannar statad.

29b. Signeture and title of certifian

29c. Licansa number

29d. Data signed (Month, Day, Year)

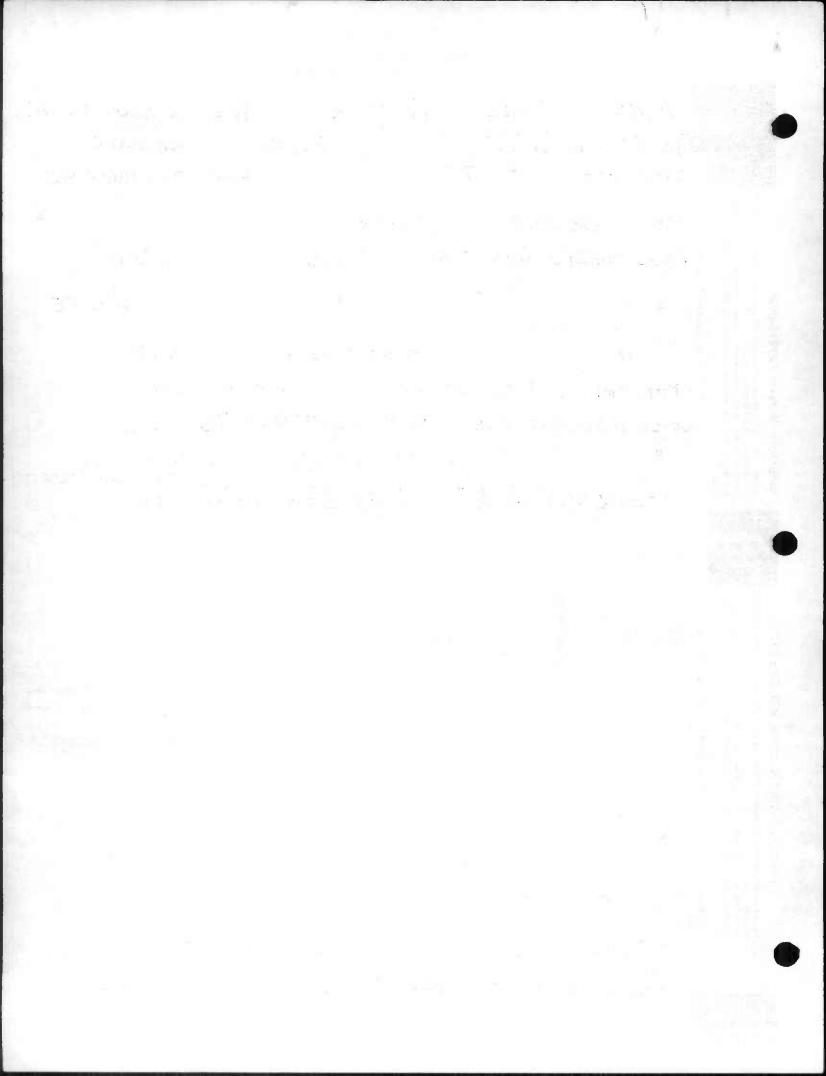
1 ☐ Yes 2 ☐ No

30. Neme and addrass of person who completed causa of death (Itam 23a) (Type, Print) 215 Bloomingdale

Melinda Butler 31. Dete filed (Month, Day, Year)

32. Registrar's Signature FEB 1 8 2000

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Bertha Lechliter February 10, 2000 7:25 am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland
If Under 24 Hrs. | 8 D Allegany 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) May 13, 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** Months Days 1 M 2 F MD 92 Ves 217-28-9925 1907 Director Usual Rasidance of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yas 2 No Director Allegany MD Cumberland 10f. Zip Code 10e. Street and Number 10o. Citizen of What Country? Nerva 23e 11807 Homewood Street 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?... 13. Was Decedent of Hispanic Origin? (Specify Yaa or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 Ao If Yes, Giva Year or Dates: filed within 72 hours after 1 Navar Married 2 Married 8 Baltimore, Maryland 21215-0020 1□Yes 2□No Specify Specify: white p 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retired Nurses Aid Sylvan Retreat 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be former of Health and Mental Haart; If Nem 27 is marked off jury or other traumetic even Be Henry L. Harbaugh (Michaels) Laura M 19a. Informant's Name/Ratationship (Type, Print)
Phyllis I. Vanderhout 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 11807 Homewood Stree; Cumberland MD 21502 204 Melino or Disposition 20b. Place of Disposition (Name of cametary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Waurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Mary's Cemetery 2/14/ Cumberland, MD 21. Signatura of Funaral Service Licensee 22 Scarperiffineral Home P.A. Cumberland, Maryland 23a. Part1. Entar tha disease, or polications that caused the shock, or haert failura. List a ly ona cause on each line. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in death) a. ACUTE RESPIRATORY FAILURE Examiner Due to (or as a consequence of) Examiner b. ASPIRATION PNEUMONIA L1 DAY sicien and burial-trensit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): physicien s the buriel Box 68760. Physician/Medical Due to (or as a consequence of) 50 use signed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy Completed should complation of causa of death? page 2 s 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funerei 27. Mannar of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 5 Panding investigation after death. 1 Yes 2 No 2 Accidant the 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stafa) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 6 24 hours Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 24 hor To the Fune completely fi (Check only To the 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

NOB

(4

31. Data filed (Month, Day, Year) FEB 1 4 2000

Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 32, Registrar's Signatura

30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print)

D23371

2000

February

FEB 14 2000 Journ 1st appealed

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dey Physician Natale Herbert James 12:50 p.m. February 11, 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cumberland Allegany 902 Harding Avenue Months Days Hours Min. 8. Date of Birth Year) 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) Funeral 10M 20F MD 71 Yrs. 216-22-6384 Director **Usual Residence of Decedent** permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Menisi Hygiens. Important: If item 27 is marked other than "natural", or hams 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Allegany Cumberland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21502 USA 902 Harding Avenue Funeral Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 21215-0020 1□ Yes 2□No Specify: white P 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) retired Tire Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) (Bahzelli) Pasqualle Natale Marie J 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 944 1/2 Weires Avenu; LaVale MD 21502 19a. tnformant's Name/Reletionship (Type, Print) James P. Natale 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home2/12/ Cresaptown, MD 22Scarperii Funeral Home P.A. Cumberland, Maryland ications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, no cause on each line. 23a. Part1. Enter the disease, or postshock, or heart failure. List enly Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examine V(h)( The law requires that the death certificate be executed physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical O Due to (or as a consequence of ... P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24a. Wes an eutopsy performed? After this certificate has 20 No 1 Yes 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2000 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 Abetural 2 Accident efter deeth.
I Director: Ah 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 4 ☐ Homicide To the Mospital of within 24 hours of To the Funerel D completely filled filled Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Gn NOB D19318 February 11, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) (10) 517 Oldtown Road; Cumberland, MD 21502 N.A. Ranjithan, M.D.; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 4 2000 Registrar

188 1 200 James & Las

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic	ian	Decedent's Name (First, Middle Helen	e, Last) Marie		Poho	ertson		2. Date of De Month Feb	10°, 20	) Agg	3. Time of Deal 09:15p			
/Medi		4e. Facility Name (If not institution			NODE	ELCSOIL	4b. City, Town, or i				03:13b			
⊏ăaiiiii	ier	Cumberland 1				211	Cumber		- 40. Ooding		legany			
Funeral Director		5. Social Security Number 216-18-1866	6. Sex 1 □ M 2 □ <b>X</b>		last birthday) 74 Yrs.	If Under 1 Year Months Deys		8. Date of Bir Month, Da Aug	1h Year) 192	9. Birthp	place (State or For			
* III		Usual Residence of Decedent  10e. State 10b. County		10c. C	ity, Town or Lo	ocetion				1	Od. Inside City Lin			
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23a or	Funeral Director	10e. Street and Number 135 N. Mecha	anic Str	eet A	pt. 90	10f. Zip Code	21502	2	10g. Citizen of USA		ntry?			
ral', or items	by	11. Maritai Stetus  1 Never Married 2 Married 3 Widowed 4 Divorced	If Vac Gi	0	J,S. 13.	Was Decedent of if Yes, specify Cut 1☐ Yes 2☐ No		can, Puerto Ricen, etc.)			ace - Americen Indian, leck, White, etc.			
"natural".	eted	15. Deceden (Specify only higher			16a. Deced	deni's Usual Occu kind of work done	pation during most of wor	king	16b. Kind of B	usiness/Ind	dustry			
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nd Mental Hygi marked other imatic event, t	o Be C	17. Father's Neme (First, Middle, Arch Robine							e (First, Middle, Maiden Sumame) ( nmn )					
rat	T	19a. informant's Name/Reletions Boyd L. Robe	hlp (Type, Print)		19b. Mailir 135	ng Address (Stree N. Mec	tand Number or Ru hanic St			State, Zip	MD 2150			
it of Heelth If Itam 27 or other tra		20a. Method of Disposition 1  Kurial 2  Cremation	3 Demouslation		Place of Dispo	sition (Name of matory or other pla	ice)	Date	20c. Location -	City or To	wn, State			
ant: It		4 Donation 5 Other (S)		State				2/14/ Cumberland, MD						
Department of important: If any Injury or once.		21. Signature of Funerel Service	Licensee	/		Scarpe	1915 Fune	eral Ho	ome P.A	Α.	,			
		23a Pert1' Enter the disease or	consilications that of	Wolle	ih Do not ent		land, Ma	_		)2	Approximate			
ysician		23a. Pert1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.	III. DO HOLOIR	or the mode or dy	ing, such os cardioc	or respiratory as	1001,	1	intervel Between Onsei end Deat			
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ste hes	mo:							101	res 2 No		Yes 2 No			
is certificate he director, page		25. Was cese referred to medical examiner?					26. Place of Dee	th (Check only o	ne)					
this ca	2	1 Yes 2 Alo		•	ER/Outpetien	I JLI DOA		ome 5 Resid			1)			
After funer	tion:	27. Manner of Death  1 Denetural 5 Pending		f Injury n, Day Year)	28b. Time of Injury	Wo	ryat rk?  Yes 2 □ No	28d. Describe how injury occurred						
To the Funeral Director: After this complately filled in by tha funeral	Certification:	2 Accident Investig 3 Sulcide 6 Could n 4 Homicide determi	of Injury - At h	ome, farm, stre	eei, factory, office	1165 2 110	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Funeral Funeral	edical C	29a. Certifier 1 Cartifying (Check only one) 2 Medical E	Physician: To the la examinar: On the ba and mann	sis of examina	wledge, deeth tion end/or Inv	occurred at the tilestigation, in my o	me, dete and piece, opinion, deeth occur	and due to the dred at the time, d	ceuse(s) and me date and plece,	nner as st and due to	ated. the ceuse(s)			
To th		29b. Signature end title of certifier	01	/	/	29c. Licens	se number		29d. Daie signe	d (Month, L	Day, Year)			
		set 1	Molle	w		100	D 4981	-	Johna	111/	7. 2000			
2			11/100			-	//4/		700 0000	WY	, 2000			
5		30. Name and address of person v	no completed cause	of deeth (item		Print)	0 4981 07. Cu	2	2	9,2	, 2000			

15.57.57.010 James & Markey

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dev Year Pansu C. Stair February 9, 3:10 pm 2000 4a Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Memorial Hospital Cumberland **Allegany** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y. 10/18/10 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) Days 10 M 2 F 89 212 24 0160 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Hyndman Bedford 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? 15545 USA 1319 Hyndman Road 14. Race - American Indian Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yas 2 Ø No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specity: White 3. Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Materials Handler Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alice Guard Robert Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 464 Cooks Mills Road, Hyndman, PA 15545 Wayne Stair/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cramation 3 Removal from Stete Hyndman, PA 2-12-00 Hyndman Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA SUR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS CEREBROVASCULAR ACCIDENT Due to (or as a consequence of) 3 YEARS CEREBROVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE, ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours affect Department of Health end Mental Hyglene.
Important: If item 27 is marked other than "natural", or ther eny Injury or other treumatic event, the Medical Exemples

altimore, Maryland 21215-0020

death

Director

Funeral

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Completed

Be

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Physician/Medical Examiner physicien and s the buriel-tren as signed by the a by Completed page 2 certificate or Attending Physician: funeral director, 8 Certification: To this

Division of Vital Records, P.O. Box 68760,

After 24 hours after death.
Funerel Director: A filled in by Hospital To the

within 2 6

Medical completely

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Huma Shakil, 31. Date filed (Month, Day, Year)

27. Mariner of Death

1 Delatural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending invastigation

6 Could not be determined

ng Shall

Registrar



28a. Date of Injury (Month, Day Year)

1 Department 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Johnson Heights Medical Bldg., Cumberland, MD

28c. Injury at Work?

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

D 46346

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

February //

21502

29d. Date signed (Month, Day, Year)

2000

**DHMH 16 Rev 6/95** 

29b. Signature and title of certifier

FEB 14 2000 James & Louis

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year **Physician** Thomas Stanley Smith February 5, 2000 cation of Death 4c. County of Death 7:53PM/Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Memorial Hospital If Under 24 Hrs. 8. Date of Birth Feb 28, 1905 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign County) **Funeral** Days 1 M 2□ F Hours Months 216-38-1612 Director 94 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be motified at 1 ☐ Yas �☐ No Directo Oldtown MD Allegany the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 USA Rte. 1 Box 33-Wilson Road Funeral 12. Wes Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Detes: X Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas → No Specify: Specify: white A 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be flied wit.
Department of Health and Mental Hyglens Important: if flem 27 le marked other tha any hojury or other treumatic event, the lange. retired farmer farming 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be (Crouse) Sarah E Harvey Smith 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 18319 Oldtown Rd SE; Oldtown, MD 21555 Minnie Miller 20 . Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burlai 2 Cramation 3 Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Cemeter2/08/ Cumberland, MD 21. Signature of Funeral Service Licenses 25 Carpetriffuneral Home P.A. Cumberland, Maryland Do not enter the mode of dying, such es cardiac or respiretory arrest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) a Coronary Artery Disease Examiner 2 years Due to (or as a consequence of): Examine certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events buriel-tran and Due to (or as e consequence of): physician a the buriel Box 68760 Physician/Medical thet initieted events rasulting in death) Lest Due to (or es a consequence of) 88 attending 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Winknown Records. by 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? peen has 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 100 2 this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury et Work? 28d. Describe how injury occurred After t Certification: or Attending 5 Pending investigation s after death.

I Director: Aft 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Contifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manyler stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 20 2000 15, (5) D36766 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Poonai M.D. 922 National Highway Cumberland MD 21502 Vikramaditya

State Registrar 31. Date Hiled (Month, Day, Year) FEB I 5 2000

32 Registrar's Signetura

FEB 13 2000 June & make

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death FEBRUARY II 2000 OLAN PAUL WOTRING 18:15 PM 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) CUMBERLAND
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) ALLEGANY CO NURSING HOME ALLEGANY If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) 1♥ M 2□ F Months Deys 98 Yrs. 214-05-6246 13 1902 MARYLAND JAN Usuel Residence of Deceden 10s Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1- Yes 2 □ No MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 204 FULTON STREET 21502 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 ▼ Married 1□Yes 2√No Specify Specify: WHITE 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 LABORER GROCERY\_STORE 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) WILLAIM W. WOTRING PRISCILLA HOPE MASON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) P.R. REV ROBERT HYMES 204 FULTON STREET CUMBERLAND MARYLAND 21502 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Buriel 2 Cremetion 3 Removel from State HILLCREST CEMETERY FEB 14 2000 CUMBERLAND MARYLAND 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME PA 23a. Pertf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting In deeth) emper Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): thet Initieted events resulting in death) Lest Due to (or es e consequence of): 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? no ( 2/2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature end title of gentifier 29c. License number an

within 24 hours after deet To the Funeral Director: To the

Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Directo

Funerai

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Completed

? is marked other than "naturel", or items 23a or 28a-f eho traumatic event, the Moutcal Examines must be notified at

other than "naturel", or

filed within 72 hours efter death Hygiene.

Pages 1 end 2 should be fill ment of Health and Mental Health and Mental Health fill them 27 is marked oth

permit. Pages Department of Important: If Its any Injury or o

**Physician** 

Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

the attending physician end hed for use as the burial-transi

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or Attending Physician:

page 2 should be

funeral director,

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Examiner

Physician/Medicai

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Certification:

edical

Baltimore, Maryland 21215-0020

the Meryland

RANJI THAN 31. Dete tiled (Month, Day, Yeer) FEB 1 4 2000

V.A.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

517 OLDTOWN ROAD CUMBERLAND MARYLAND

21502

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State	of Mar			artment o				ental Hy	ygier Reg. 1	UU	06	083
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	Physician /Medical		Francis	Josep	h	W	eise	enmill	ler			Feb	11,	Dey 2000	0	9:25am
	Examine	rľ	ta Facility Nama (If not institution Allegany Cou			Hom	e		C	umbe	rlan					gany
	Funeral Director		5. Social Security Number 217-18-4280	6. Sax 1 M 2 □ F	7. Aga (	76	birthday) Yrs.	Months D	Yaar Days	If Under: Hours	Min.	B. Date of 8 (Month 1	Jay, Yes	1923	9. Birthple Countr	Ca (State or Foreign
	P	-	Usual Residence of Decedent  10a. State 10b. County	,	1	Oc. City, T	own or Lo	ocation							10	d. Inside City Limits
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	6 9 5									USA	f What Country?					
020	ors after dos aft, or flams Examiner m	o a miles	11. Marital Status  1 Navar Married 2 Mar  3 Widowed X Divorce	12. Was De frmed I Yes If Yas, (Year or	cedent Ever Forcas? 2 No Date WW			Was Decedent If Yes, specify		spanic Orle n, Mexican Specify:		ify Yas or N ican, atc.)	lo-	14. Race Black, Specify:	Whita, a	tc.
5-0	72 ha natur Scal	7010	15. Deceder	nt's Education est greda completed	1)	1	6a. Dece	dent's Usual C	Occupa done d	ation lu <i>ring mos</i> i	t of working	a	16b.	Kind of Bus	lness/îndu	ustry
21215-0020	led within 72 ha tygiene. her than "naturn it, the Medical.	-	Elementary/Secondary (0-12)	(Give kind of work done during most of working life. DO NOT use retired)  Plumber & Steamfitte							Cum	b. Lo	cal	Union		
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Maryland	nd 2 should be 27 in men		19a. Informant's Name/Relation Jean Connell	ship (Type, Print) <b>ey</b>		3	19b. Meili 19 I	ng Address (S Fayett	Street e	Stre	er or Rural	Route Num umbe	rla	nd, N	tete, Zip (	1502
ore,	of Hear of Hear I literal	1	Sister 20e. Method of Disposition 18 Burial 2 Cremation	2 Demoved from	n State	20b. Place ceme	e of Dispo	osition (Neme metory or othe	of er plec	a)		Date	20c.	Location - C	ity or Tow	n, State
tim	Page ment ant: If		4 Donation 5 Othar (S		II State	SS P	etei	Paul	C	emet	ery2	/14/	Cu	mber]	land	, MD
Saltimore	emit epart mport ny in		21. Signature of Funeral Service	Licansee	1		11/2	Scarpe	4TT	1 Fu	hera	1 Ho	me	P.A.		
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ı			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause or	t caused the each line.	e death. [	Do not en	ter the mode o	of dyin	g, such as	cardiac or	respiretory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. A	spi	rat	(Tr		Pn	eu	MUS	mia			1	o days
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8760,	De de de	3	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury													
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	the atter thed for the		Part II. Other significant conditi	ona contributing to	death but r	not resultin	ng In the u	inderlying caus	sa give	en in Part I	l,	23b. Df	d tobac	co uae cont	ribute to	the cause of death?
P.0	that the detac		SPC:	V.A E	di	pp	ha	gia	,	Hyp	erfens	10	☐ Yes	2 No	3 🗌 Prob	ably 4 Unknown
Records	requir		C.O.P.I	J-Se	ver	e				01		24a. Wa	as an au rformed		CON	re autopsy findings ilable prior to apletion of cause aath?
Re	sician: The law s certificata has b director, page 2 s											10	Yes	20 No		Yes 2 No
Vital	entifica ector, p	)	25. Was case referred to medica	al						26. Place	e of Death	(Check only	y one)			
> 1			examiner? 1 ☐ Yes 2 No		] fnpatient		/Outpatie		_	4 LXNU	ursing Hom	e 5 Re	sidence	8 DOther	(Specify	)
ion	Attending Plant of the funeral by the funeral filtration:		27. Menner of Deeth  1 Natural 5 Pendi 2 Accident invest	ng (Mo	e of Injury onth, Dey Y	(ear) 28	b. Time o	of 28c.	. Injun Worl	yat k? Yes 2□		8d. Describ	e how li	njury occurre	d	
Division of	or Atternation of the control of the		3 Suicida 6 Could 4 Homicide determ	not be nined 28e. Ple buil	ca of Injury Iding, etc. (	- At home (Specify)	, farm, st	reet, factory, o	office		2	8f. Location City or 7	(Street own, St	end Numbe ate)	r or Rural	Routa Number,
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	within 2 To the comple		29b. Signature and title of certific	ər	2			29c. L	lcens	number			29d.	Date signed	(Month, E	Day, Year)
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	0	1	Name and appress of person	who odmolyted ca	use of deal	th (Item 23	За) (Туре,	Print)	7	1	mh	onla	m	mi	) 21	502
-			The Day Of The Town	MALLE	Danietro	A U	MAC	WILL T	1	Lu	1110	4 14	14	110	01	100

Registrar

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 06084 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Yaar Month February 22. 2000 6:30 P.M. Loretta M. Abel 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Johns Hopkins Bayview If Under 1 Year 8. Data of Birth (Month, Day, Year) Sept. 22, 1924 If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) Months 1□M 2XF Maryland Yrs 75 218-12-0384 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4780 Elison Avenue 21206 U. S. A. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whife, etc. 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 💢 No If Yas, Giva Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White 16e. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th Grade Laborer Paper Company 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maidan Sumama) John L. Little Florence U. Hubbard 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) George L. Abel Jr. (Son) 2955 Burnley Court, Abingdon, Maryland 21009 20b. Plece of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata Most Holy Redeemer 2/26/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home Inc. MayeT 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onsat and Death CARDIAC Immediata Causa (Final ARRYTHMIA day 9110 diseasa or condition rasulting in death) Dua to (or as a consaquenca of): Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as e consequanca of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown protic aldio vascula 24b. Ware autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? Seane 1 Yes 2 No 1 Yas 2 HO 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 2 1 No 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Examiner physician and s the bunal-transit P.O. Box 68760, been signed by the a should be deteched certificate or Attending Physician: Certification: To this 24 hours after death.

Funeral Director: After

Physician/Medical Completed by Be

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

"natural", or items 23s or 28s-f show

permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a any Injury or other traumatic event, the Medical Examiner must bodge.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

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Records, Division of Vital

State Registrar

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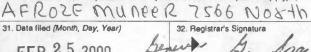
31. Data filed (Month, Day, Year) FEB 2 5 2000

29b. Signetura end titla of certifiar

4 Homicide

(Check only one)

29a. Cartifiar



e munell

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

1 Certifying Physician: To tha best of my knowledga, death occurred at tha time, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) and manner stated.

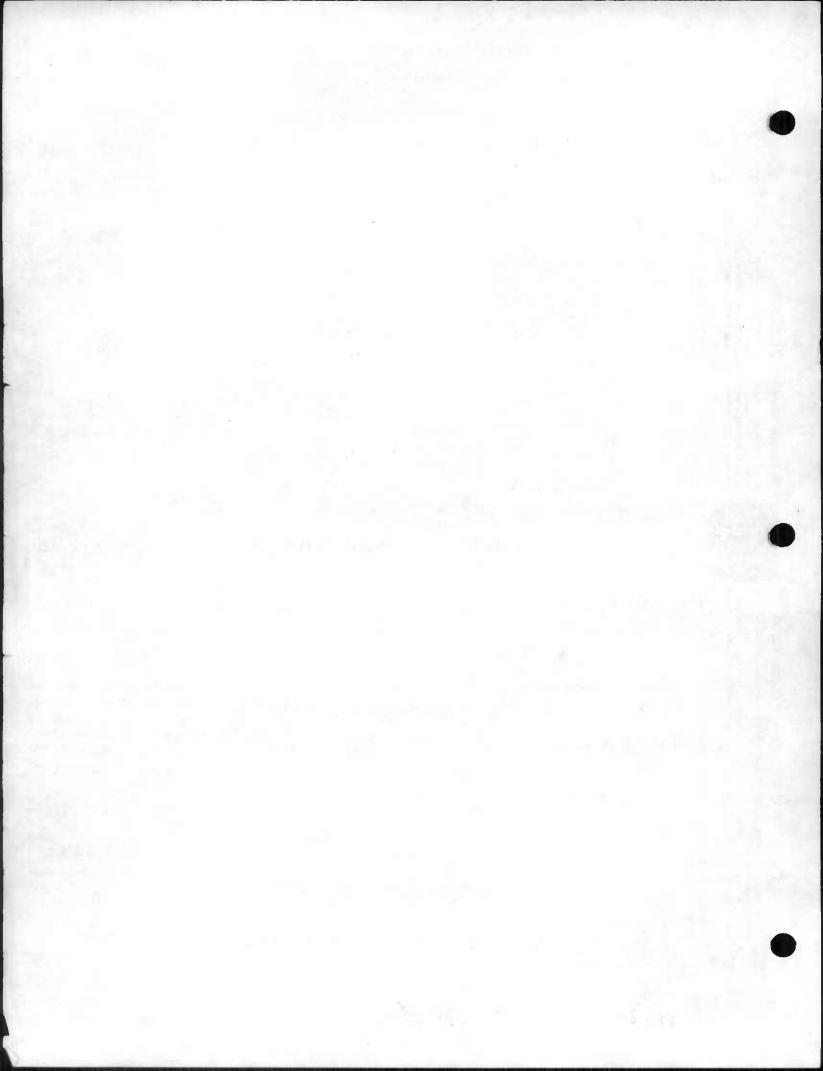
29c. License number

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29d. Data signed (Month, Day, Year)

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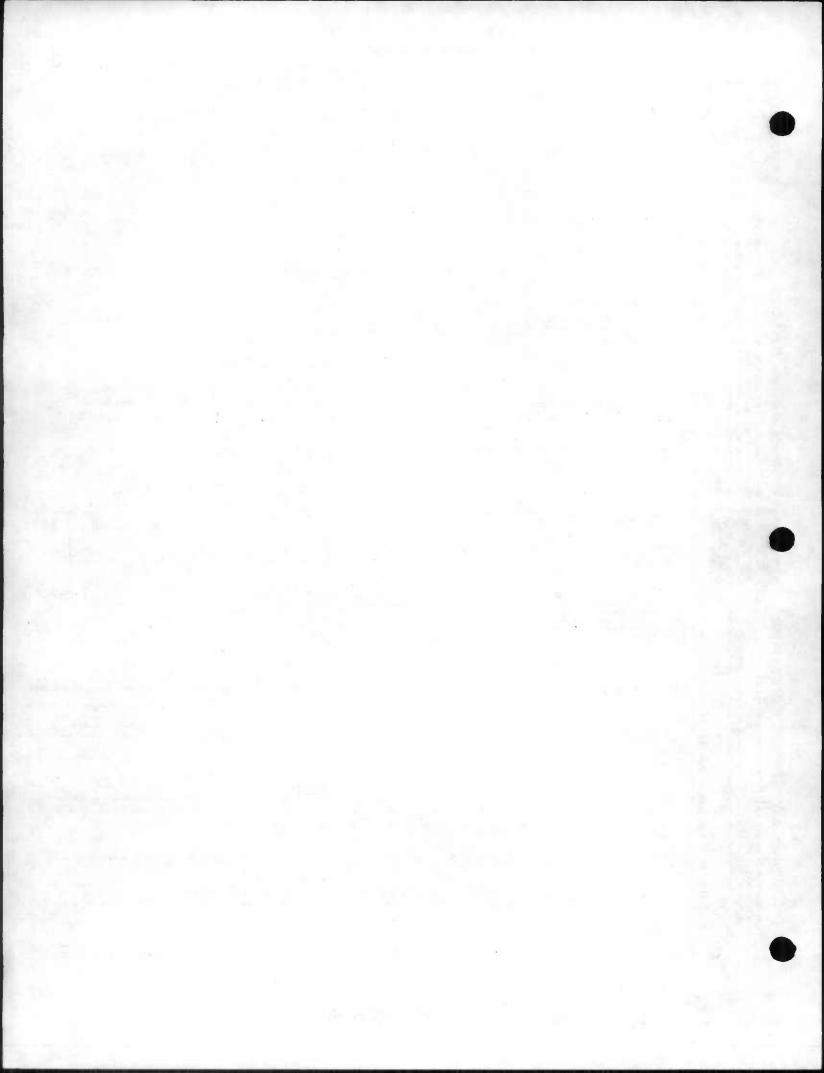


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06085 Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** a sanaszerus erruary 2305 21 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death .se. County of Death Examiner Medic Ba Ce timore a Hours Min. SEPT. 8, 1919 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1□ M 21 F 80 Yrs 218-01-2871 Director MD. Usual Residence of Decedent death with the Meryland 10d. Inaide City Limits 10a. State 10b. County 10c. City, Town or Location ms 23s or 28s-f show Yes 2□No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23s or 931 S. OLDHAM ST. 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Waa Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, e filed within 72 hours after du il Hygiena. other than "natural", or frem Black, White, etc. 1 Yes 27 No 1 ☐ Never Married 2 ☐ Married aitimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: WHITE P 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed v Department of Heelth and Mental Hygle Important: if Nem 27 is marked other th eny injury or other traumatic avent, the page. 6TH OWN HOME HOMEMAKER 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 8 GRIFFITH LENA KNORR 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE J. BANASZEWSKI 931 S. OLDHAM ST., BALTIMORE, MD. 21224 20b. Place of Disposition (Nama of cometary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 2/25/2000 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturified Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, App. 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, App. 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, App. 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, app. 25a. Part1. Enter the disease, or complications that caused the death. 21224 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pue Due to (or as a consequence of) physician a the burle Box 68760 nt initiated events sulting in death) Last Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by been si 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 1 Yes 2 TNo 1 Yes 2 No certificata Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20300 une 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) BUNCE ANTONIA MD Johns 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar 2 5 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** ,25 Mary Jary 22 2000 Febr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltinare CH If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) DEC. 21, 5. Social Security Number 6. Sev Geriatrics Center N/A ff Undar 1 Year 7. Age (In yrs. last birthday) **Funeral**  Birthpiace (State or Foreign Country) 220-03-5768 15 M 2□ F Months Days 82 Yrs. Director MD. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show Director MD. N/A Yes 2□No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7023 CONLEY ST. 21224 Funeral USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yas 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than traumatic event, trained. Elementary/Secondary (0-12) Coilege (1-4or 5+) 5TH HOMEMAKER OWN HOME Maryland parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important. If New 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be MORRIS FUGATE EDNA HENDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08757 19a. informant's Name/Relationship (Type, Print) MARY MCINNIS 1098 EDGEBROOK DRIVE SOUTH, TOM RIVER NJ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 2/25/2000 BALTIMORE, MD. 21. Signature of Funeral Service Licansee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Part. Env. the disease or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, PALTIMORE, PACTOR AND ADDRESS OF COMPLETE OF CONTROL interval Between Onset and Death **Physician** /Medical immediate Cause (Finai Imonth ung cancer disaase or condition resulting in death) **Examiner** Bue to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 80 for use P.O. I Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown metastases Records, p 8 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? emphysema, congestive heart failure 25. Was case referred to medical examiner? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No artery disease Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; p Be 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturai 5 Pending Investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) State

Michele

5505 Hopkins Boyview Circle Baltimore, MD 21224

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** February leveland Brockington 1000 /Medical 4e Facility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland 6. Sex atv Baltmore Baltimore 5. Social Security Number Medical entu DK If Under 1 Year 8. Data of Birth (Month, Day, Year) 09-08-36 if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 12 M 2 ☐ F Yrs. 63 Director Florence, unknown SC Usuel Residence of Decedent the Maryland 10a. Stete Peges 1 and 2 should be filed within 72 hours after death with the Marylen nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-1 ehow ury or other traumstic event, the Medical Examiner man be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 11 N. Schroeder St. 21223 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) construction laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Brockington 2 Hattie Kelly 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson Brockington, Brother 4501 Homer Ave, Balto. Md 21215 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If ite eny injury or ot page. 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Mount Zion 2-25-00 Balto. Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23e. Perty Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Phelimonia bstructive Examiner Due to (or as a consequence of): Examiner archemi be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760 Physician/Medicai the Due to (or es e consequence of) signed by the e Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. #E] Unknown 1 Yes 2 No 3 Probably Records. þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 Yes 1 Yes 2 No of Vital or Attending Physician: efter death. Director: After this certifica Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 papatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division Neturel 5 Pending 1 Yes 2 No 2 Accident Investigetion 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 24 hours oft Funeral Di letely filled in Hospital edicai 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and interior as attained. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. completely (Check only one) within 2 \$ 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of com

State Registrar

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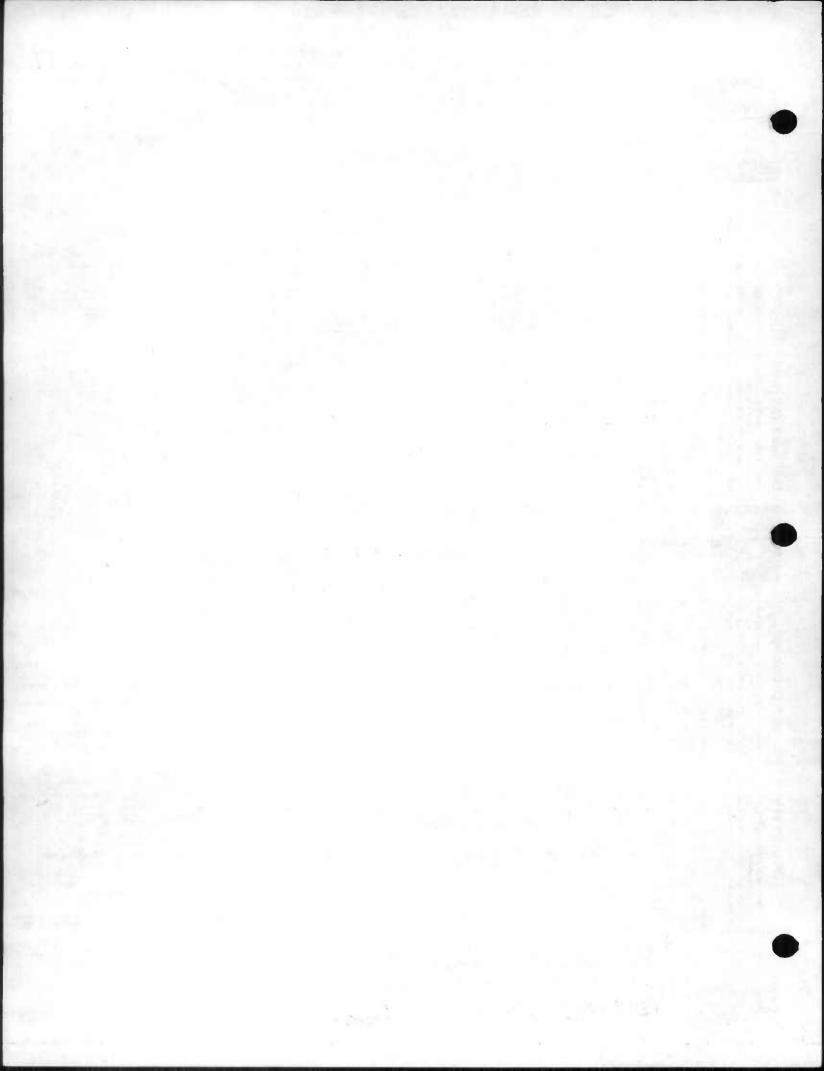
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Ana Byrd 22 Snoth

Battimore, MD

St. (neen

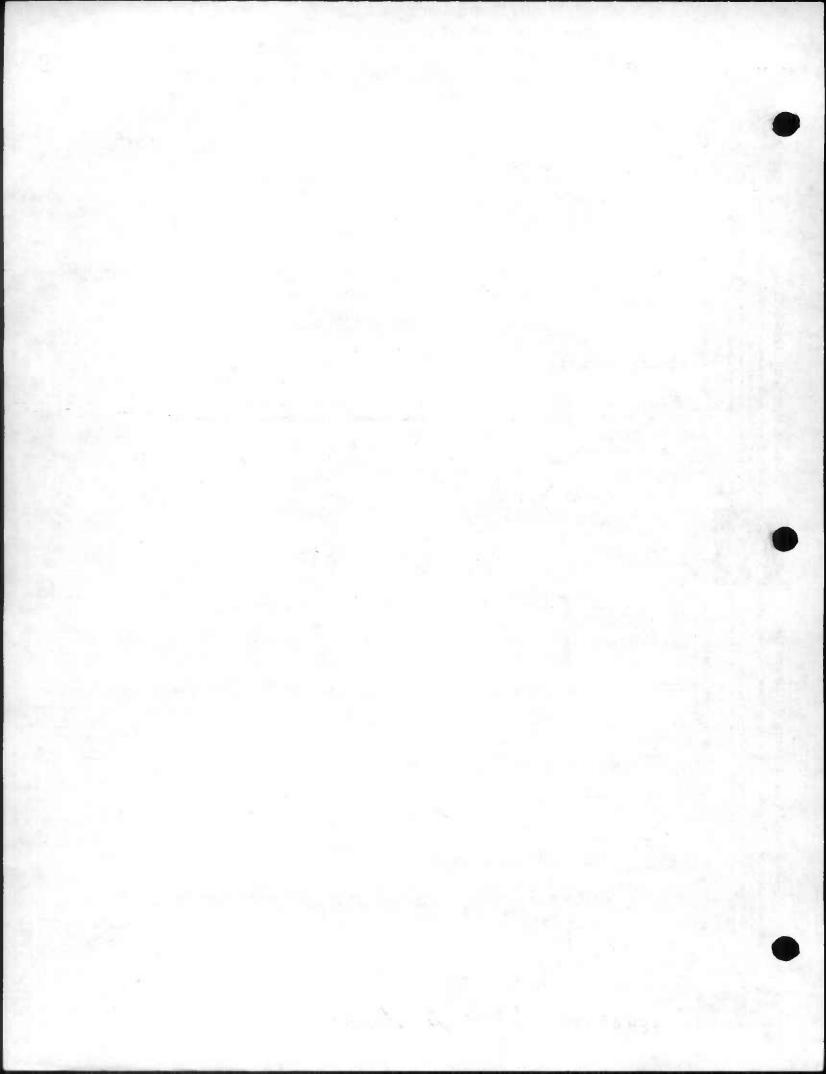
32. Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend ityem 19 b per fh PG780-2/25/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Tebruary 25 ~ 9:46 pm Drown 2000 ernice /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOSPITAL of Baltimore INAI 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days 8. Date of Birth (Month, Day, Year) 09-22-1929 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA Funeral Sex 1□M 2XF 70 Director 218-26-6907 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show 0 1 Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 21215 USA "natural", or itema 23a Funeral 3rown 3901 BAREVA RD 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than 'natural', or he my or other traumals event, the Mexical Engine my or other traumals event, the Mexical Engine. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN BEAUTY 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SUSTE V. GOODE JAMES F. BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3901 BAREVA RD., BALTO., MD. 21286 irginja Ave. MARIE MORRIS/SISTER IN LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removal from State Department of Important; If any injury or pace. GARRISON FOREST V.A. 2/29/2000 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC 9 times 1701 LAURENS ST., BALTO., M D. 21217 23a. Parf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai Due to (or as a consequence of) signed by the a Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 1000 1 Yes 2 No of Vital or Attending Physician: 25. Was/case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this funerei 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of injury 28d. Describe how injury occurred Medical Certification: 28c. tnjury at Work? Affer 5 Pending investigation Division 1 Natural 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) tebruary ted cause of death (Item 23a) (Type, Print) 2401 Ke Jr 31. Date filed (Month, Day, Year) 32. Registrar's Signature Baltimore, md. 21215 State Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time f th Month Year 3:55 Am atherine Bannister 00 2 21 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BonSecour Hospital Baltimore 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) 10 M 2/X Months Days Hours Min Yrs. 214-86-2904 36 04-09-63 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1321 W. LaFayette Avenue 21217 USA 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes X No X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th Grade Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Bannister Dorothy Wilson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21217 Apt.#315
Baltimore, MI
20c. Location - City or Town, State Dorothy Gibson 20b. Placa of Disposition (Name of cametery, cremetory or other piece) MD. 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 02-26-2000 Cacons 22. Name and Address of Facility Baltimore, Maryland 21202 re of Funeral Service Lice MA WM.C.March FH 1101 E. North Avenue 12: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) nunun Due to (or as a consequence of): Due to (or es e consequença of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed'

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Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

completion of cause of deeth? 1 🗆 Yes 23 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Dete of injury (Month, Dev Year) 28c. injury et Work? 28a 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Injury 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Dev. Year)

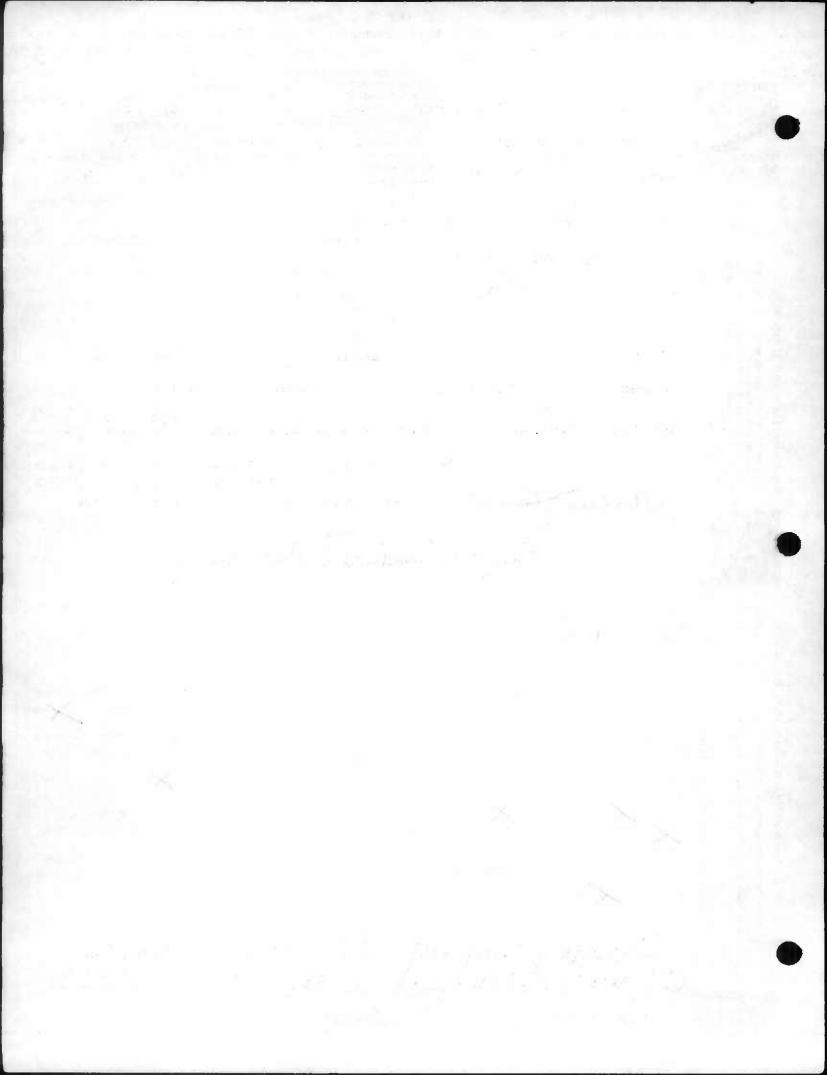
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31. Date filed (Month, Day,

29b. Signature and title of cell

FEB 25 2000 32. Registrar's Signature

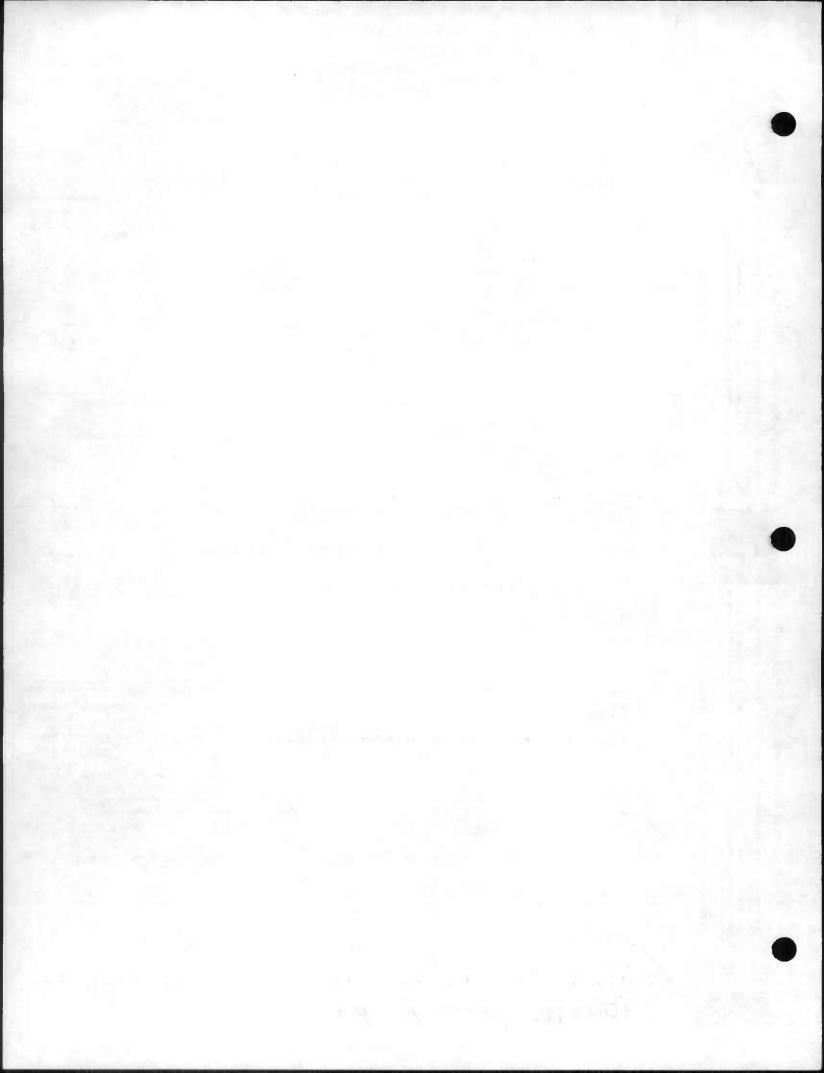
Registrar **DHMH 16 Rev 6/95** 



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State of Maryland / Department of Health and Mental Hygiene O O

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/Medical Examiner		Facility Neme (If not institution, give street end number)					4b. City, Town, or	Location of Deeth			12.20 0.111		
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To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		6 Could not be determined	00 00 00 00 00 00 00 00 00 00 00 00 00						281. Location (Street end Number or Rural Route Number, City or Town, Stete)				
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune funedical Certification	29a. Certifier 1 C (Check only 2 M	ertifying Phys edical Examin	eiclan: To the be ner: On the basi end menner	s of examineti	vledge, deeth ion end/or inv	occurred et the trastigation, in my	ima, data and place opinion, daath occ	e, and dua to tha curred et tha tima, o	ausa(s) and medata and place,	anner as s and dua to	tated. o tha cause(s)		
Within To the comp	29b. Signeture end title of	Pertifier ~		7 .		29c. Licen	se number	2	29d. Pete signe	d (Month,	Day, Year)		
, , , ,	1	with	1-	hun		00/	1150	6	2/22/0	20			
Q	30. Negre end eddrass of MELITO	person who co	in DANE	of death (Item	23a) (Type,		wood A	UF. BAI	70 W	10 2	1224		
State	31. Dete filed (Month, De)	Year)	32. Reg	istrer's Signet	ure 4	lan	1.		-10/				



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Dey Yeer 120, **Physician** FERRUARY 21, 2000 ocation of Death | 4c. County of Death Scott Calvin Bailey /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris at Mercy Hospital Hospice Baltimore If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 10XM 20 F Months 283-14-1810 Director June 24, 1914 Maryland Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Name 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6099 Babylon Crest 21045 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 72 hours after 1 Types 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black WWII Aq 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within:
Department of Heelth end Mentel Hygiene.
Important; if Nem 27 Is marked other then in any Injury or other traument. Elementery/Secondary (0-12) College (1-4or 5+) Auto Body Mechanic Auto Repair 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Stephen Bailey Martha (unk) 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William L. Wilson (POA) 6099 Babylon Crest, Columbia, MD 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel Irom State 4 ☐ Donetion 5 ☐ Other (Specify) 2/28/00 Owings Mills, MD Garrison Forest VA 21. Signature of Foneral-Service Licenses 22. Name end Address of Fecility Witzke Funeral Homes Inc. 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart leilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): signed by the atte Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy parformed? Completed peen : completion of cause of deeth? has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) STE//A MARIS AT MERC Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica he Hospital or Attending Physic in 24 hours after death. he Funeral Director; After this co pletely filled in by the funeral dire 10 1 Yes 2 No 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Naturel Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medical (Check only one) To the Pwithin 2 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier

DHMH 16 Ray 6/95

State

Registrar

BAHIMORE

30. Name and address of parson with completed cause of death (Item 23a) (Type, Print)

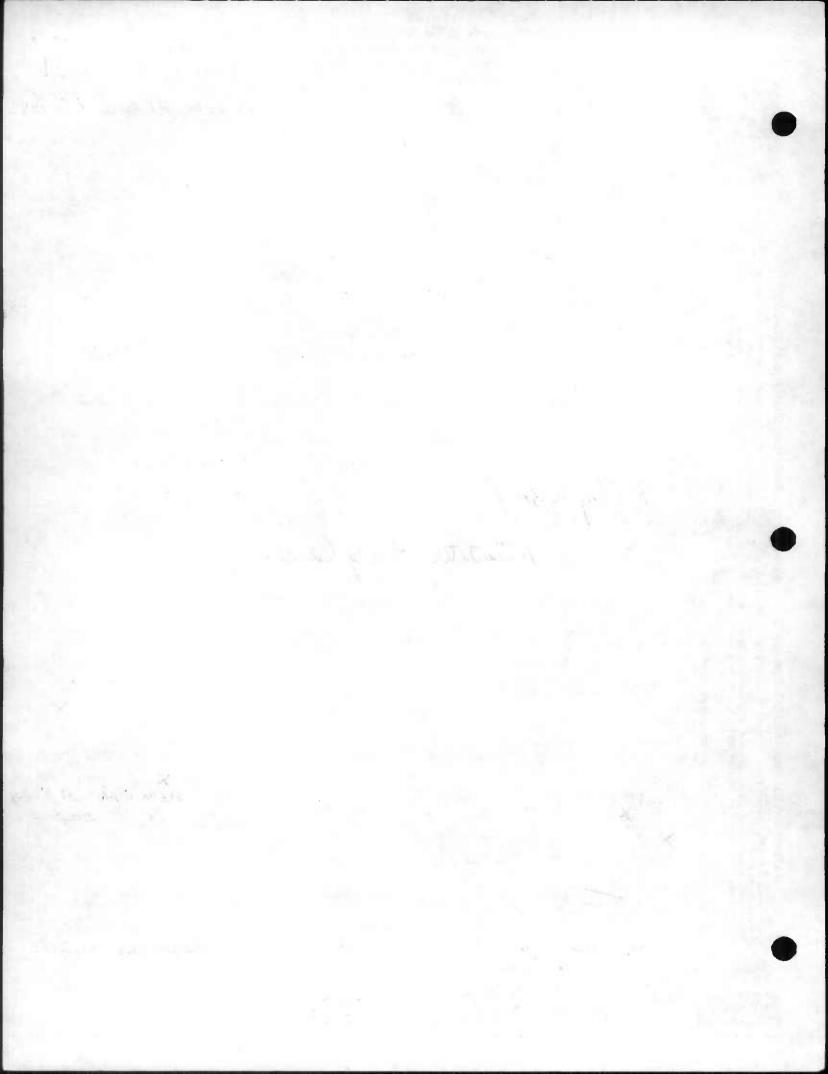
DAVID RISE BERG 30/St

FEB 25 2000

32. Registrar's Signature

Deperson

31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#24a perPhyG780 2/25/2000 EW 1. Decedent's Name (First, Middia, Last) 2. Date of Death 3. Time of Death Month February 12,2000 5:10 AM Cecilia Julia Connor 4a Facility Nema (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) April 12,1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Hours Maryland 1 M 2 F Yrs. 86 216-09-0482 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore City Maryland 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? U.S.A. 21214 2712 E. Northern Parkway Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 yr's Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Broczkowski Frances Lewandowska Anthony 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 2712 E. Northern Parkway Baltimore, MD 21214 Miss Rita F. Connor - Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cramation 3 ☐ Ramovat from State 2/15/00 Baltimore, Maryland Sacred Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funerel Sarvice Licensae Baltimore, Maryland 21214 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 3 months Immediate Cause (Final disease or condition resulting In deeth) Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were eutopsy tindings available prior to 24a. Wes en autopsy performed? completion of cause of death?

nding Physician: The law requires that the death certificate be executed on of Vital Records, P.O. Box 68760, the for use signed by the a

Examiner Completed by Physician/Medical Be Medical Certification: To

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23s or 28s-f ahow the Medical Executor must be notified at

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mentel Hygiene.
ant: if ferm 27 is marked other than "natural", or the ury or other traumate event, tra Marian

Demit. Page Department of important: if it any injury or c

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

death with the Meryland

21215-0020

Baltimore, Maryland

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25	. Wes case referred to medic	al	26. Place of Death (Check only one)											
	examiner?	Hospitel:	1 Inpatient 2	ER/Outpatient	3 D	OA Other: 4 Nursing I	Home 5 Residence	6 AOther	(Specify)	-ospic				
7.	. Menner of Death  1. Datural 5 Pend 2 Accident invest		Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 Ves 2 No	28d. Describe how i	njury occurred	d	•				
	3 Suicida 6 Could deten	not be nined 28e.	Plece of tnjury - At h building, etc. (Speci	nome, ferm, stree	t, fector	y, office	28f. Location (Stree City or Town, S		or Aural Aoute	a <i>Number</i> ,				

Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29b. Signatura and titla of certifiar

(Check only one)

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

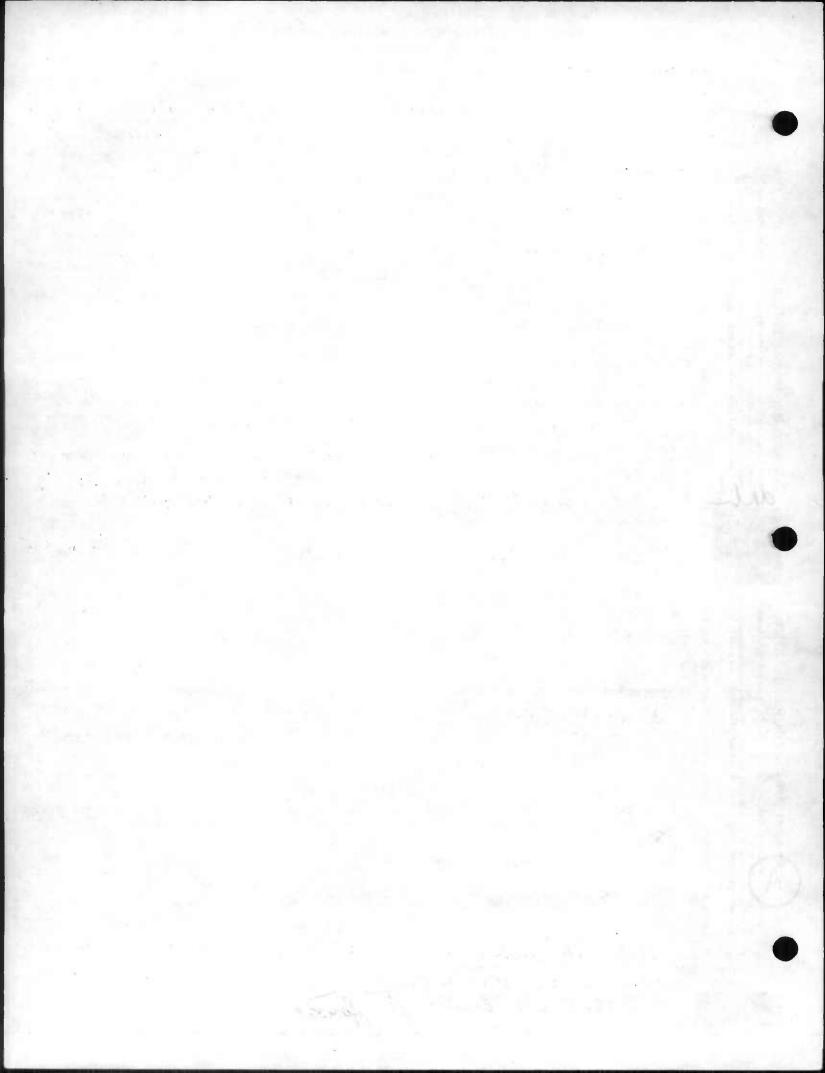
2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gardan 6565 N. Charles Baltmore MD 21204 Helen

State Registrar

2000 32. Registrer's Signature



### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene o

	1. Decedant's Nama (First, Middle, Last)	Reg. No.	05093							
Physician /Medical	Julia Ann Cooper	February 23, 2000	3:10pm							
Examiner		or Location of Death re Maryland VA	Death							
Funeral Director	5. Social Sacurity Number 211–09–1118  6. Sex 1 M 257 F  7. Age (In yrs. last birthday) 83 Yrs.  Hours M  Wonths Days Hours M  Usual Residence of Decedant	Hrs. 8. Deta of Birth (Month, Day, Year) August 10, 1916	Birthplaca (Stata or Foraign Country) PA							
death with the Maryland res 23e or 28e-1 show r.mait be notified at neral Director	10a. Stete 10b. County 10c. City, Town or Location		10d. Insida City Limits 1 ☐ Yas 2 ☑ No							
h with the Ma 23e or 28a-f s at be notified al Director	10e. Street and Number 6834 Montgomerry Road 10f. Zip Coda 201.75	10g. Citizen of Whe Unite	at Country? ed States							
9 # B		? (Specify Yes or No- uarto Rican, atc.)  14. Race - Black, 1  Specify:	American Indien, White, etc. White							
ed within 72 houn tygens. we then "netural" it, the Medical Ex Completed b	15. Decedent's Education (Specify only highast grada completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12.  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker.		nass/Industry							
of De field with Hygis and other in one or want, ith	17. Fathar's Nama (First, Middle, Last)  18. Mother's  Anna	leme (First, Middla, Maidan Surnama)								
and 2 should be filed within 72 hours all salth and Mental Hygiens. 127 is marked other than "natural", or set traumatic event, the Medical Exami	19a. Informant's Name/Reletionship (Type, Print)  19b. Mailing Addrass (Street and Number of	r Rural Route Number, City or Town, State, Zip Code) , Elkridge Maryland 20175								
semit. Pages 1 ar Department of Hea reportant: if item 2 rey injury or other 2008.	20a. Method of Disposition  **St Buriel 2 Cremetion 3 Ramoval from Stata 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Nama of cametary, crematory or other place)  Jefferson Memorial Park February	Dete 20c. Location - Cit								
permit. Departm Importa any inju	21. Signatura of Funaral Sarvice Licensee Victor P. Doda, Jr. Charles L. Stevens F. 1501 Fast. Port. Avenue	uneral Home, Inc. e, Baltimore Maryland	21230							
Physician	23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dylng, such as cershock, or haert failure. List only one cause on each line.		Approximata Intarval Batween Onsat and Death							
/Medical Examiner	Immediata Causa (Final diseasa or condition rasulting In death)  Pheumonia, Urosepsis  Due to (or es a consequence of):									
executed in and institutions it	UTT, Pheumonia, Aspiration		1-2weeks							
ifficate be g physicia as the bur fedical	Sequentially list conditions, if any, leading to immediata ceusa. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last  Dua to (or as a consequence of):  Dua to (or as a consequence of):									
the death certify the attending sched for use a hysician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contri	bute to the cause of death?							
that the ed by the detach	Chronic Renal Insufficiency, Anemia,		Probably *SUnknown							
The law requires sate has been sign page 2 should be Completed by	Dementia	24a. Wes an autopsy performed?	24b. Wara autopsy findings evallable prior to completion of cause of death?							
Physician: The law requires: this certificate has been sign ral director, page 2 should be		1 ☐ Yas 2 🔀 No	1 ☐ Yas 2 ☐ KNo							
Physician: The this certificate and director, page 1: To Be Co	axaminar?	Death (Check only one)	(Canaika)							
Attanding Physic or death.  sctor: After this or by the funeral direction: To	1   Yes 2CNo   1   1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursin	ng Home 5 ☐ Residence 6 ☐ Other (								
tal or Attanding Pris after death.  at Director: After tied in by the funers  Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number of City or Town, Stete)	or Rural Routa Number,							
ne Hospi no 24 hou ne Funer pletely fill edical	29a. Certifiar (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death or and manner stated.	ace, and due to tha ceuse(s) and mann occurred at the tima, data and place, and	ar as stated. I dua to tha ceuse(s)							
To the common	29b. Signeture end title of certifiar  We Hadren Pay 29c. License number  1359	8 2/20	1							
	30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)  Ment, Arc, MD, 87. AGnes 40)	8 2/20 Ra (1 Setting	ac imo							
State Registrar	31. Deta filed (Month, Day, Year)  FFB 2 5 2000  32. Registrar's Signetura & Aponths									

				Ce	rtificate of	Death		Reg. No.	0 1	7074		
		Decedent's Name (First, Middle, Last)					2. Data of De	ath	V	3. Tima of Death		
Physici /Medi		Sue Lynn Corneli	us				Feb. 2	23, Day 200	0 O	1520		
Examir		4a. Facility Nama (If not institution, giva street and number	or)	4b. City, Town			Location of Death	4c. County	4c. County of Death			
		Union Memorial Hospita	a l			Balti			N/	' A		
Funeral Director		5. Social Security Number 2 1 3 - 4 4 - 9 6 5 5  Usual Residence of Decedent  7. / 1	Age (In yrs. last t	Srs.	If Under 1 Yaa Months Days		. (Month, Da	th y, Year) 23,1946	9. Birthp Coun Mar	lace (State or Foreign try) 'yland		
land ow		10a. State 10b. County	10c. City, To	wn or Lo	cation				1	0d. Inside City Limits		
ath with the Maryland 23a or 28a-f show	to	Maryland N/A		Bal	timore					NDYes 2□No		
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Coun	try?		
h wit	aiD	3939 Roland Avenue	e Apt.	101		21211			US	S A		
effer des	by Funeral	11. Marital Status  1 □ Never Married   1 □ Never Married   1 □ Ves X□ If Yes, Give If Yes, Give	s? XNo		Was Decedent of If Yes, specify Cul		Specify Yes or No rto Rican, etc.)					
		3 Widowad 4 Divorced Yaar or Dates		a Dans	dentile I town I Com		ation					
T 6 1 5	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	kind of work done  DO NOT use retin	pation during most of w ed)	orking	16b. Kind of Bu	siness/inc	Justry		
2121 d within giene. rr than "	отр	Elementery/Secondary (0-12) College (1-4o	10+)			sistant						
Hygin other	Be C	17. Father's Name (First, Middle, Last)	31	1161	, ing no	T	ame (First, Middle,			1140 00.		
re, Maryland 212 s 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Itam.	To B	James Franklin Kis	ner			He1	en Hein	ball				
ary s mar	-	19a. Informant's Name/Relationship (Type, Print)		b. Mailir	ng Address (Stree				Stete, Zip	Code) 2 1 2 1 1		
md 2 alth e alth e 27 is		James Cornelius Hust								nore, MD		
Baltimore, Nomine Pages 1 and Department of Health Moderant: If item 27 my injury or other than 27 my		20a. Method of Disposition	20b. Place		sition (Name of netory or other pla		Date	20c. Location -				
Pages sent of 5 nt: If ite		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			of Fai		2/26/00	Fulle	rtor	, Maryla		
Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Poneral Service Ligages	1		2. Nama and Addr		2/20/00	Laire	1 001	i, maryra		
Balt permit. Departminimports any inju		A Tens VIII and	1-11-	——B	urgee-	Henss-S	eitz Fu Balti	neral	Home	, Inc.		
-	4 4	Charge H. Cary	enly	3 ر	8631 Fa	11s Rd	Balti	more,	MD 2	1211 Approximete		
		23 Part   Enter the disease or complications thet/dise shock, or heart failure List only one cause of each	The.	HOL BIIL	er the mode or dy	ing, such as cardi	ac or respiratory at	rest,	1	Interval Between Onsat and Death		
Physician /Medical	Immediate Cause (Fin)											
Examiner		disease or condition resulting in death)										
	<u>-</u>		Due to (or as a	consec	(uenca of):							
ted nsit	Examiner	b. Sins	15	_ C	quenca of):	elihi						
and and	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	conseq	uence of):							
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or the de by the dached	ysic	Part II. Other algnificant conditions contributing to death					23b. Dld	tobacco use cor	tribute to	the cause of death?		
- 5 D B	by	Chrunic Pancretic	In	Su 7	herene	7	10	Yes 2 No	3 Prot	bebly 4 Unknown		
	Completed	Chang Stirvid L	Mage				24a. Was perfo	an autopsy rmed?	ava	ere eutopsy findings allable prior to mpletion of cause death?		
Il Rec	шо						10	res 28 No	1	Yes 2 No		
Vital I	0	25. Was case referred to medical				26 Place of Di	eath (Check only o					
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Division o  To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Sulcide 4 ☐ Homlolde  6 ☐ Could not be determined  28e. Place of I building,	njury - At home, etc. (Specify)	farm, str	eet, factory, offica		28f. Location (: City or Tox	Street and Numb vn, Stete)	er or Rura	l Route Number,		
To the Hospital of within 24 hours a To the Funeral D completely filled in the Funeral	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the bess and manner:	of examination a	ge, death and/or inv	occurred et the t restigation, in my	ime, dete and pled opinion, deeth occ	ee, and due to the curred et the time,	ceuse(s) end me date end plece, o	nner as st and due to	eted. the ceuse(s)		
To the To the Somp	Me	29b. Signature and title of certifier		29d. Date signed	(Month,	Day, Year)						
		Mahad lakar la	11 M	1	1)3	4680		2/2	4/0	D		
		30. Name and address of person who completed cause	death (Item 22s	(Type	,	_			// 0			
4		Michal A Randiph A	10 3	333	N. GL	IERT ST	A USS BA	ILT MO	2	1218		
Sta Registr	_	FFR 2 5 2000	strar's Signature	9	Book	2						

Chargest Constitution

00-1026-510 jhm MARIE DARRELL

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental H Certificate of Death

Hygiene	UU:	0	5		0	6
Reg. No.		U	U	U	2	-

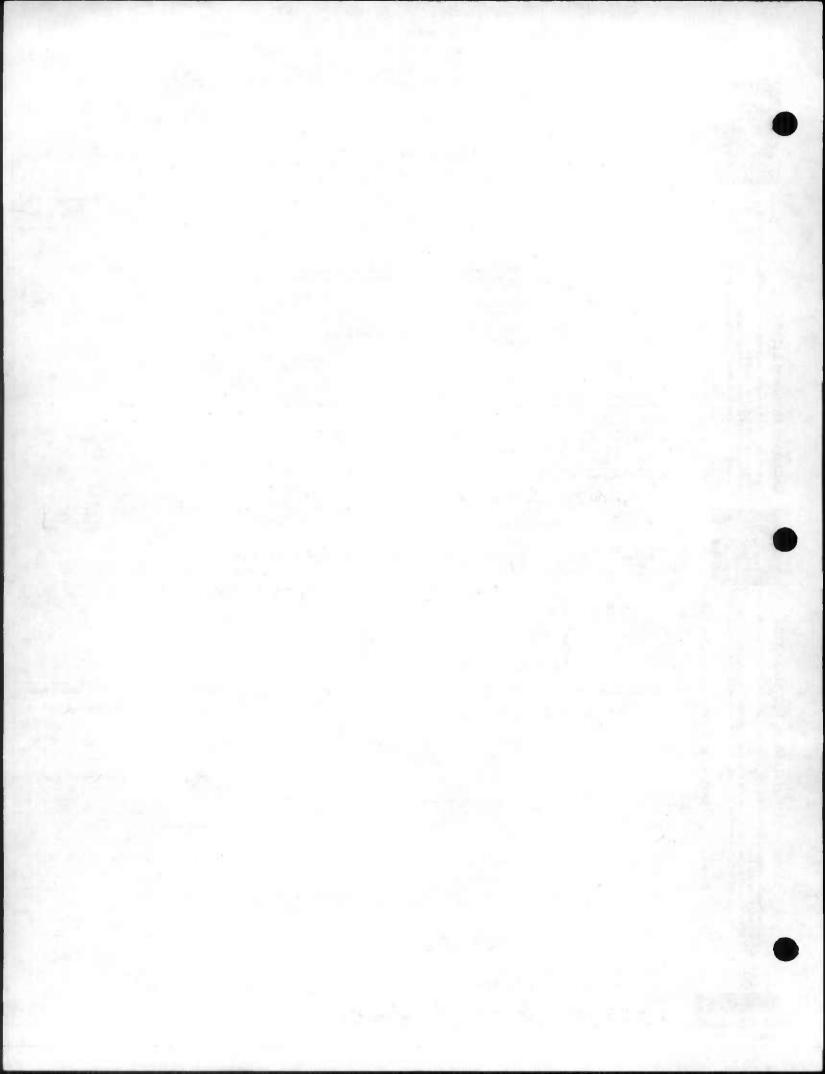
	Physiciar /Medica Examine
Ī	Funeral

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit tate has been signed by the attending physician end page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

n al	1. Decedent's Name (First, MARIE		ast) DARREL	L							2. Date of De Month FEBRUA	Day	Year 2000	3. Time of Death 21:28 PM	
ai er	4a Facility Name (If not ins 3501 DILLON			umber)					4b. City, To BALT	IMOR	cation of Deat E	h 4c. County	of Death	9.000	
	5. Social Security Number 214-44-696	4	Sex 1□ M 2√2 F	7. Age (1 56	'in yrs. last b	virthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MAY 18	th ly. Year) 3, 1943	9. Birthple Countr	ce (Stete or Foreig y) MD	
1000	Usual Residence of Deced  10a. State 10b. 0		A	1	Oc. City, Too BAI		ocation MORE						10	d. Inside City Limit	
DI DI DI DI	10e. Street and Number 3501 DILI	ON	ST.			T	10f. Zip		21224			10g. Citizen of USA	of What Country?		
27	11. Marital Status  1 Never Married 2[ 3 XWidowed 4 Direction		12. Wes De Armed I 1 Tes If Yes, C Year or	Forces?	er in U,S.	100	Wes Deced If Yes, spec	ify Cubi	lispanic Ori an, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	Bla	ce - America ck, White, et v: WHI!	c.	
		highest g	Education rade completed College	(1-4or 5+)		(Give	dent's Usua kind of wor DO NOT us	k dona	during mos d)	t of work	orking 16b. Kind of Business/Industry SALES				
	17. Fether's Name (First, M FRANK DARK		st)								Name (First, Middle, Maiden Surname)				
	19a. Informant's Name/Re DONNA GOLD			IN								er, City or Town,			
	20a. Method of Disposition  1 Burial 2 Crem  4 Donetion 5 Ot	etion 3			20b. Place	of Dispo	osition (Nan	ne of	ce)		Date	20c. Location BALTI	City or Tow	m, State	
cal Examiner															
	Part II. Other significant or OS Rug	onditions		death but r	not resulting	in tha u	indartying c	ause giv	en in Pert I		-	tobacco use co Yes 2□No		the cause of death	
			15.00								24a. Was perfe	an autopsy ormed?	avai	e autopsy tindings lable prior to ipletion of cause eath?	
	25. Wes casa refarred to mexaminer?	nedical	Hospital:					Ott	non-		h (Check only	100		Yes 2□ No	
	2 Accident	Pending investigati	28a. Date (Mo	Inpetient e of Injury onth, Day Y	(ear)	Time o	M 2	Bc. Injui Wor	4 LI NI		28d. Describe	dence 6 Oth	rred		
27. Manner of Death   Mailtanum   S   Pending investigation   S   Could not be determined     28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No     28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No     28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No     28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No     28a. Date of Injury   28b. Time of Injury   28										ber or Rural	Route Number,				



00-0700-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene LILLIAN DORSEY JVWAmended Item#26 perPhyG780 2/25/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year FEBRIJARY 07, 2000 Month **Physician** 0900 A.M. LILLIAN DORSEY /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1716 WEST LAFAYETTE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 16, 1923 5. Social Security Number Birthplace (State or Foreign County)
 UNKNOWN 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Yrs. 76 Director unknown Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flams 23s or 28s-f show must be notified at 1 Yes 2 No Director unknown unknown unknown unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral unknown unknown 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: unkno Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unknown 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: black à 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumane) Known permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If Item 27 is marked other 17. Father's Name (First, Middle, Last) Be 2 unknown unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C. M. E. 111 Penn Street Baltimore, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Ø Other (Specify) in state 21. Signature of Funeral Service Licensee Renald S. Wade 22. Name and Address of Facility
State Anatomy Board irector 655 W. Baltimore Street me lale Baltimore, MD 21201 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Hypertensive Arteriosclerotic Cardiovascular Disease disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner complicated by HYPOTHERMIA ding physician and se as the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edificete be Physician/Medical Due to (or as a consequence of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? O tores 2 No 3 Probably 4 Unknown ۵. þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu has 1 Yes 2 No 1☐Yes 2☐ No certificate or Attending Physician: 25. Was case referred to medical axaminer?

1 1 4 es 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5XXResidence 6 (Other (Specify) Scene Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury unk 1 Natural subject exposed to low death. 02/07/00 1 Yes 2 No 2 X Accident after death Director: evironmental temperature 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
Vacant bldg. 4 Homicide 1716 W. Lafayette 21217 To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 20 Hedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. dine)

State Registrar

29b. Signature

Laron Locke M.D.

and addrass of person who completed cause of death (Item 23a) (Type, Print)

Dex Year 275 -20082. Registrat's Signeture

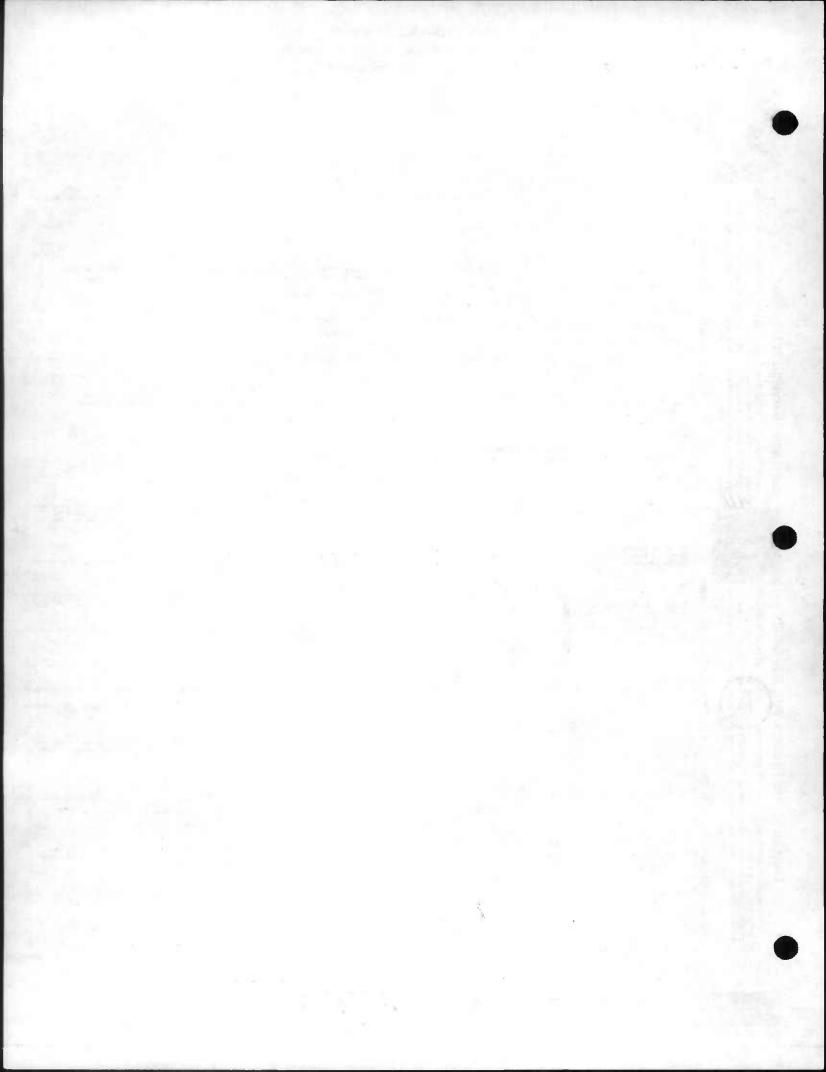
29c. License number

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 07, 2000



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Re	eg. No.			
	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Deer			
sician edical	VINSON DAVIS		FEBRUMM	Day 19. Z	600 12:45 A		
edicai miner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or L					
	UNION MEMORIAL HOSK	11EAL BALL	IMPORE	-			
	5. Social Security Number 6. Sex / 7. Age (In yrs. last	birthday) If Under 1 Yeer If Under 24 Hrs.			9. Birthplace (State or For Country)		
	222-05-7625 WM 20F 79	Yrs. Months Days Hours Min.	10-20-	1920	Country) VA		
	Usuat Residence of Decedent						
		own or Location			10d. Inside City Lin		
ğ	MD BAL	LIMORE			1 ☐ Yes 2 □		
by Funeral Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of W	hat Country?		
0	1000 WARTH CLONIES ST	11018		11.5	4		
Jers	11. Mantal Status 12. Wes Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. It Yes, specify Cuban, Mexican, Puerto	? (Specify Yes or No- 14. Raca - American In				
F	1 Never Married 2 Married 1 Yes 2 No		Hican, etc.)	k, White, etc.			
þ	3 Widowed 4 □ Divorced It Yes, Give Year or Dates:	1 Yes 2 No Specify:		Specify:	BLACK		
	15. Decedent's Education 1	6e. Decedent's Usual Occupation		16b. Kind of Bu	siness/Industry		
Be Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king				
E	Elementery/Secondary (0-12) College (1-4or 5+)						
Ö	17. Father's Neme (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, A	Maiden Sumam	9)		
8	NOTIC DAVIC	n NXI	E	-1111	10		
10	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ral Boute Number				
			AVI- A	Pal In	md niniz		
	20a. Method of Disposition 20b. Place	e of Disposition (Name of	AVE B	20c Location	City or Town, State		
	1 Purial 2 Decemption 2 Demouslitem State Came	etery, crematory or other placa)					
	4 □ Donation 5 □ Other (Specify) MET	10 CREMIATORY INC.	2-23-00/	BALLIN	ORE, MD		
DDC8	21. Signature of Funeral Service Licensee	22. Name end Address of Facility 40  AVE, BALLIMORE	600 LID	ERTY	Heights		
1	18 St bull	- AVE, BALLIMOR	E. MO	2 21%	2017		
	23a, Part1, Enter the disease, or complications that caused the deeth. [				Approximete Intervat Betwee		
, 📙	shock, or heart tailure. List only one cause on each line.				Onset and Dea		
	Immediate Cause (Final	al Thrombosis					
	resulting in death)	s a consequence of):			1		
ě	Due to for as	s a consequence ory.					
edical Examiner	b. Due to for su	s e consequenca ot):					
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s o consequence ory.					
Ca	Cause (Diseese or injury C.	s e consequence of):					
7	resulting in death) Lest	s e consequence ory.					
3	d		,				
Clar							
Physician	Pert If. Other eignificant conditions contributing to deeth but not resulting	ng in the underlying cause given in Part I.			itributa to the cause of d		
4			1 Y	es 2 No	3 Probably 4 ∑Un		
1 by		•	04- 144-	o automa	24b. Were autopsy tind		
tec			24a. Was a parforr		evailable prior to completion of cause		
호					of death?		
0			1 🗆 Ye	es 2200	1 ☐ Yes 2 ☐ No		
is certificate has been si director, page 2 should To Be Completed	25. Was case referred to medical	26. Plece of Dee	th (Check only on	ne)			
	exampiner?	VOutpatient 3□ DOA Other: 4□ Nursing H	ome 5 Reside	ence 6 Othe	er (Specify)		
Be	1 Yes 2 No Hospitat: 1 ☐ Inpatient 2 ER		28d. Describe ho	ow injury occum	ed		
To Be	27. Menner of Death 28a. Date of Injury 28	3b. Time of 28c. Injury at Work?	28d. Describe how injury occurred				
To Be	27. Menner of Death  The Theturet 5 Pending investigation investigation 28a. Date of Injury (Month, Day Year)  28 Determine 20 EN	Bb. Time of Injury at Work?  M 28c. Injury at Work?  1 \( \text{Yes} \) 2 \( \text{No} \)		on (Street and Number or Rural Route Number			
To Be	27. Menner of Death Theturet 5 Pending investigation 3 Suicide 6 Could not be able to be a content of the conte	M 1 Yes 2 No	28t. Location (St	treet and Numb	er or Hural Houte Number		
To Be	27. Menner of Death  To Returet 5 Pending investigation  3 Suicide 6 Could not be	M 1 Yes 2 No	28t. Location (St City or Town	treet and Numb n, State)	er or Hural Houte Number		
To Be	27. Menner of Death 1	M 1 ☐ Yes 2 ☐ No e, tarm, street, tactory, office	, and due to the ca	n, State) ause(s) and ma	nner as stated.		
To Be	27. Menner of Death Theturet Capacident Capa	M 1 ☐ Yes 2 ☐ No e, tarm, street, tactory, office	, and due to the ca	n, State) ause(s) and ma	nner as stated.		
Be	27. Menner of Death   To Price   To Price   To Price	M 1 ☐ Yes 2 ☐ No e, tarm, street, tactory, office	and due to the cirred at the time, d	ause(s) and ma	nner as stated.		
edical Certification: To Be	27. Menner of Death   Top	M 1 Yes 2 No e, tarm, street, tactory, office  adge, death occurred et the time, dete end plece in and/or investigetion, in my opinion, deeth occu	and due to the cirred at the time, d	ause(s) and ma	nner as stated. and due to the cause(s)		
edical Certification: To Be	27. Menner of Death   To Private Priva	M 1 Yes 2 No e, tarm, street, tactory, office  adge, death occurred et the time, dete end piece of and/or investigetion, in my opinion, deeth occurred et the time of the time	and due to the cirred at the time, d	ause(s) and ma	nner as stated. and due to the cause(s)		
edical Certification: To Be	27. Menner of Death   To Private   1   Second   28a. Date of Injury   28a. Date of Injur	M 1 Yes 2 No e, tarm, street, tactory, office  adge, death occurred et the time, dete end plece of and/or investigetion, in my opinion, deeth occu  29c. License number  DA7683  Ba) (Type, Print)	and due to the corred at the time, d	ause(s) and ma	nner as stated. and due to the cause(s)		
edical Certification: To Be	27. Menner of Death   To Private Priva	M 1 Yes 2 No e, tarm, street, tactory, office  adge, death occurred et the time, dete end piece of and/or investigetion, in my opinion, deeth occurred et the time of the time	and due to the cirred at the time, d	ause(s) and ma	nner as stated. and due to the cause(s		

**ORIGINAL** 

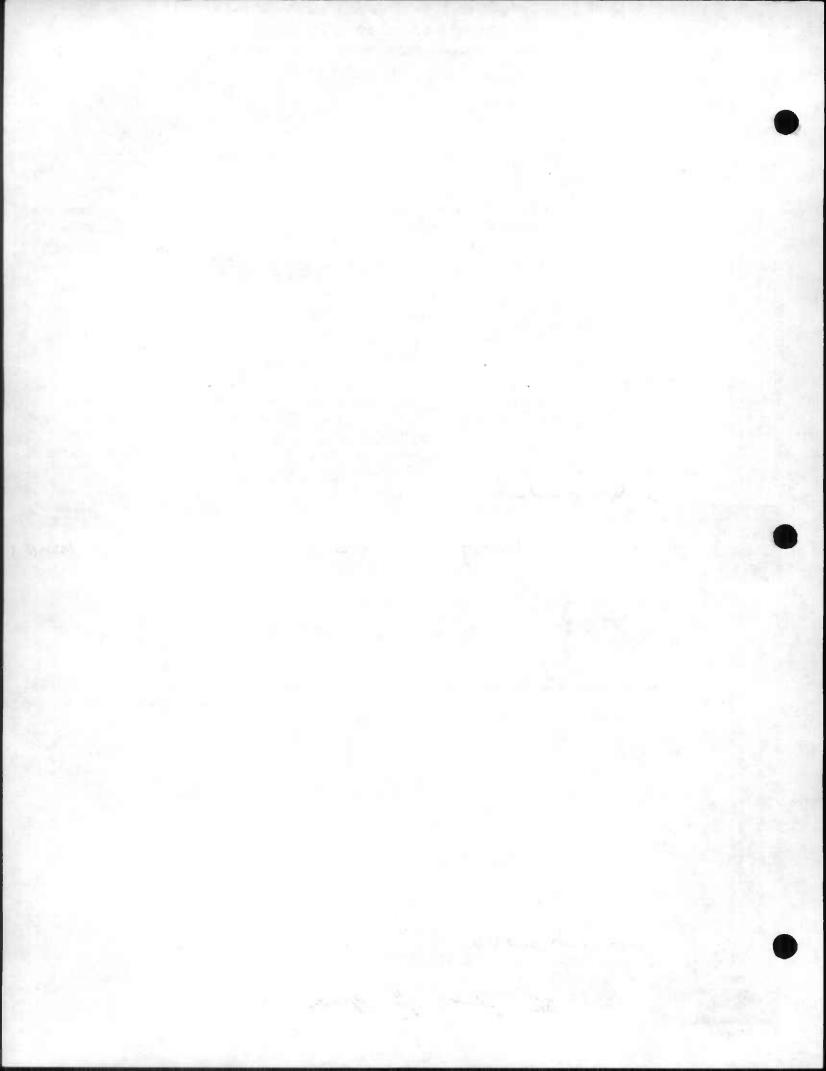
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Route

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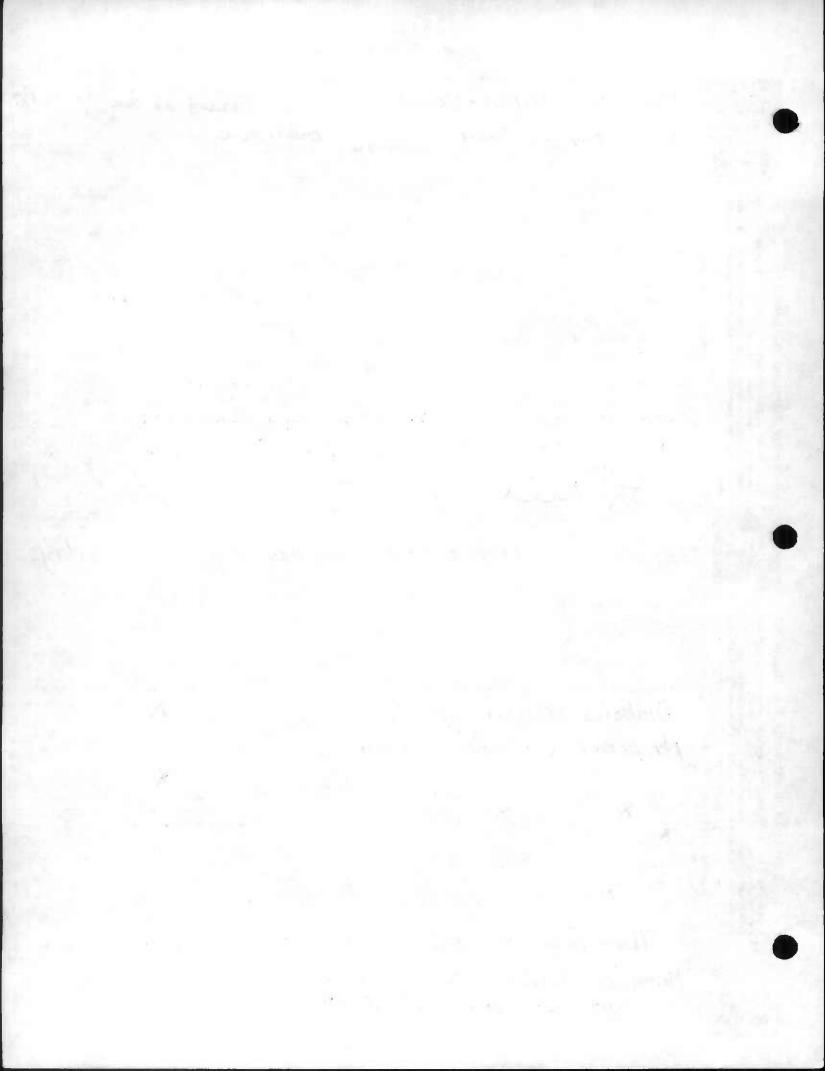
State of Maryland / Department of Health and Mental Hygiene 00 06098

			C	ertificat	e of	Death			Reg. No.	, ,	009	0	
Physician	Decedent's Nama (First, Middle, Last     DOROTHY MAE DICK	1)						2. Date of De Month FEBRUAL	ath	Year OOO	3. Time of 2:30		
/Medical Examiner	4a Facility Name (If not institution, give 8376 W.B.& A RD.	street and number)				4b. City, Too SEVE	wn, or Lo			of Death	DEL		
Funeral Director	220 30 7237	7. Age (I ☐ M 2 1 58	n yrs. last birthde Yrs.	Months		If Under a	24 Hrs. Min,	8. Data of Bir (Month, Da JUNE 2	th ly. Year) 1, 1941	Cour		r Foreig	
28a-f show notfined at ector	Usual Residence of Decedent  10a. State 10b. County  MARYLAND ANNE ARU		C. City, Town or EVERN	Location						1	0d. Inside Cit		
0 8 6	10e. Streat and Number 8376 WB&A RD.	RV Hale		10f. Ziç	Code 1144				10g. Citizen of V UNITED				
natural, or Herra 23 deal Examinar must	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	rin U,S.	If Yes, spe	cify Cub	lispanic Orig an, Mexican Specify:	gin? (Spe , Puerto	city Yes or No Rican, etc.)	o- 14. Race - American Indian, Bleck, White, etc.  Specify: WHITE		etc.		
than "natur than "natur than "natur than "natur than "natur than "natur	15. Decedent's Edi (Specify only highest grad		16a. De	cedent's Usu	al Occup	pation during most	of worki	na	16b. Kind of B	usiness/Inc	dustry		
Hygiene	Elementary/Secondary (0-12)	College (1-4or 5+)	life	EMAKER	se retire	d)			OWN HO	ME			
Be See	17. Father's Nama (First, Middle, Last)  JAMES THOMAS FORD	, SR.						M. BAI	, <i>Meiden Suman</i> RWICK	ne)			
Dra al	19a. Informant's Name/Relationship (7) JAMES G. DICK, JR		100000						er, City or Town, AND 2114		Code)		
755	20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	1 1 1 1 1 1	rematory or o	other pla			Data EB. 28 2000	20c. Location -			LANI	
Department of I Important: If Its any Injury or of phos.	21. Signature of Funded Service Dennise  22. Name and Address of Facility  KIRKLEY-RUDDICK FUNERAL HOME, P.A.  421 CRAIN HWY., S.E., GLEN BURNIE, MD												
nding physicien and use as the bunel-transit	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b	e to (or as a cons	sequence of):							O MI	on	
e attend of for us	Part II. Other significant conditions co	ation to death had				un in Dad I		non Did	tobecco use co	-0-10-10-0	- Ab	of doct	
ed by the detache	Parti. Other significant conditions co	narioding to death but in	or resulting in the	unosnying c	ause gr	veri in Parti.					bably 4		
shoul						vTV		24a. Was	an autopsy ormed?	87	ere autopsy fi ailable prior to impletion of ci death?	0	
certificate has irector, page 2								10		10	Yas 2	No	
SE P	TE TAS ZEINO		2 ☐ ER/Outpet		JA	her: 4 Nu	rsing Hor		dence 6 □Oth		(ע		
Affer Affer I	27. Menner of Death  1 Naturel 5 Pending  2 Accident Investigation  3 Suicide 6 Could not be 4 Homicide	28a. Date of Injury (Month, Day Yo	- At home, farm,	М		ry at rk?  Yes 2 ☐ I	No	28f. Location (	how injury occur		al Route Num	iber,	
within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Phy	building, etc. (5 sician: To the best of m ner: On the basis of ex	y knowledge, de	ath occurred	at the ti	me, date and	d place, a	City or To	cause(s) and ma	anner as s	tated.		
within 24 To the F complete	one)	and manner stated	- INTERIOR AND THE				ar occurre	or at the thire,	1100				
200	29b. Signature and title of certifier	2-M.D		290		505			PEBRUAR				
	30. Name and address of person who completed cause of death (Nam 23a) (Type, Print) YUDHISHTRA MARKAN, M.D., 1600 CRAIN HWY., SUITE 602, GLEN BURNIE, MD 21061												
State	31. Data filed (Morth.PB 2-5 2	32. Redistrar's	Signature	9 1	oon	h		<del> </del>					



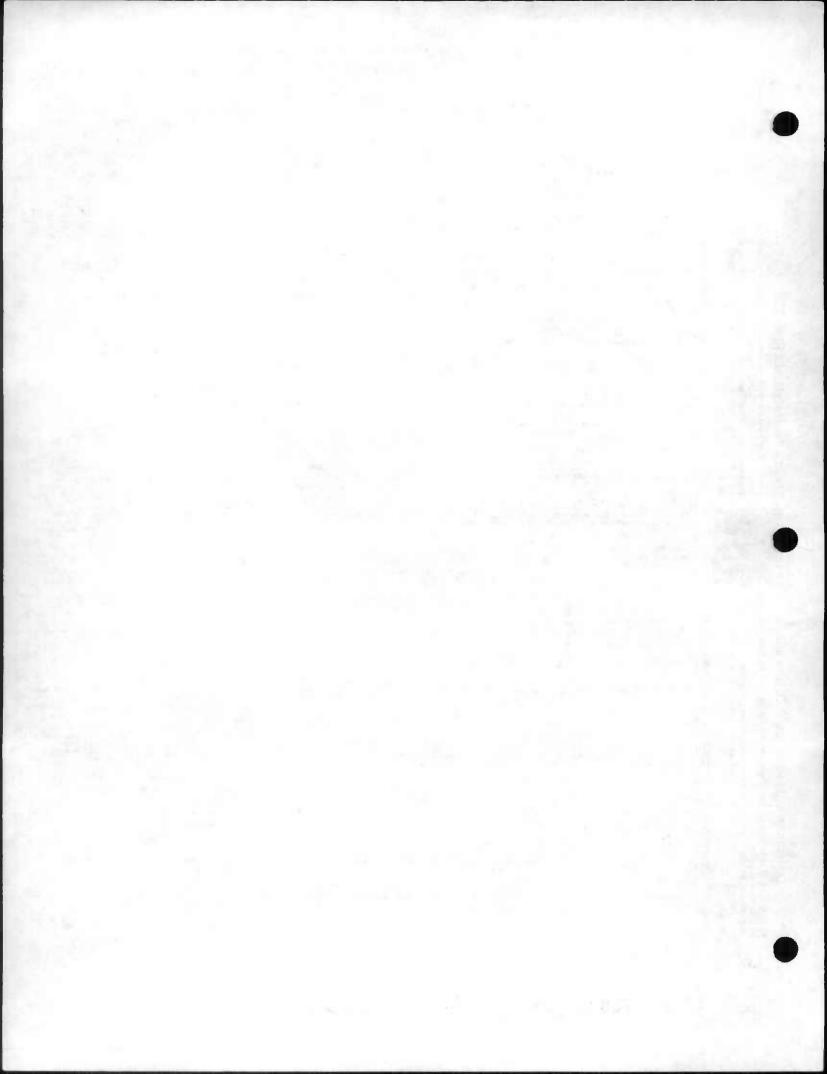
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate	of Death	Reg. No.	06099		
Physician	1. Decedent's Nama (First, Middle, Last)		Data of Death Month Day Ye	3. Time of Death		
/Medical	Mercedes Duran-Sosa	Fe	bruary 23 ac	par 12:35 Pm		
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location		Death		
	Harbor Hospital Center	Ball mos	BALTIMO			
Funeral Director	212-17-5336 12 m 257 78 Yrs.	Year If Under 24 Hrs. 8. g eays Hours Min. M.	BALTIMO Date of Birth Month, Day, Year) ARCH 21, 1921	Birthplace (State or Foreign Country) DOMINICAN REP.		
pu *	Usual Residence of Decedent  10a, Slate 10b, County 10c, City, Town or Location			10d. Inside City Limits		
with the Maryland a or 28a-f ahow the notified at Director	MARYLAND ANNE ARUNDEL GLEN BURNIE			1 □ Yas 2 No		
vith the Ma t or 28e-f a be northed	10e. Street and Number 10f. Zip Co	de	10g. Citizen of Wha	t Country?		
23a or	508 MCPHERSON RD. 210		DOMINICAN			
fler death v	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent Armed Forces? 13. Was Decedent It yes, specify	of Hispanic Origin? (Specify Cuban, Mexican, Puarto Rica	Yes or No- n, etc.) 14. Race - /	Amarican Indian, White, etc.		
by by	Armed Forces? Il Yes, specify  1 ☑ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No  1 ☐ Yes 2 ☑ No  1 ☑ Yes 2 ☐ Yes			OOMINICAN		
natural dical Ex	15. Decedent's Education 16a. Decedent's Usual C (Specify only highest grade completed) (Give kind of work of the completed)	ecupation	16b. Kind of Busin	ess/Industry		
d d	Elementary/Secondery (0-12) College (1-4or 5+)	one during most of working etired)				
ther the	0 HOMEMAKER		OWN HOM	1E		
5 0	17. Father's Name (First, Middle, Last)		st, Middle, Meiden Sumame)			
TOE	CARLOS DURAN	CRISTOBALI				
2 €			ute Number, City or Town, Sta			
them 27 other to	20a. Method of Disposition 20b. Place of Disposition (Name		BURNIE, MD 210	161		
5 = 5	1 Burial 2 Cremation 3 Mamoval from State 4 Donation 5 Other (Specify)	r place) FEB.	Pate 200. Location - City or Town, State DOMINIC SAN CRISTOBAL, REPUBL			
important: any injury page.	KIRKLEY		RAL HOME, P.A., GLEN BURNIE,	MD 21061		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.			Approximate		
as been signed by the ettending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examiner	disease or condition resulting in deeth)  Due to (or as a consequence of):  B. Due to (or as a consequence of):  b. Due to (or as a consequence of):  cause (Disease or Injury that initiated events resulting in death) last  Due to (or as a consequence of):			O		
ettending physics as the clan/Medica	rasulting in death) Last  d.					
ed for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23b. Did tobacco use contril	bute to the cause of death?		
igned by the bedeathed by Physic	Diabetes Mellitus type II		1 Yes 2 No 3	Probably 4 Unknown		
2 should	Peripheral Vascular discase		24a. Was an autopsy performed?	4b. Were autopsy lindings available prior to completion of cause of death?		
page 2			1 ☐ Yes 2 No	1 Yes 2 No		
certificate h rector, page	25. Wes case referred to medical	26. Place of Death (Ch	neck only one)			
90	examiner?  1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA	Other	5 ☐ Residence 6 ☐ Other (	Specify)		
to the far	27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year)  28b. Time of Injury M	Injury at Work? 1 Yes 2 No	Describe how injury occurred			
us or Attending to a life death.  Is after death.  Is I Director: After to led in by the funer.  Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pleca of Injury - At home, farm, street, factory, o building, etc. (Specify)	fice 28f. I	Location (Street and Number of City or Town, State)	or Rural Route Number,		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et to 2 Medical Examiner: On the basis of examination and/or investigation, in and manner steled.	he time, dete and place, and o my opinion, death occurred at	dua to the cause(s) and manne t the time, date and place, and	er as stated.  dua to the cause(s)		
Within To the comp		cense number	29d. Date signed (A	Aonth, Day, Year)		
	Jama, MD	12293	February	1.23, 2000		
7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Hanover Street	et Baltimore	c mo a1225		
State Registrar	31. Date filed (Month, Day, Year) See Signature & Signature & Space	K				



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Last)		Certifica	ate or t	Dealli	2. Date of C		3.	Time of Death
hysician /Medical	Willie 1	ree Fos	TER			Month O2	21 2	Year	1530
Examiner	4s Eacility Name (If not institution, give s	treet and number)			b. City, Town, or	Location of Dea	ith 4c. County	y of Death	
	Deaton Univer  5. Social Security Number  6. Sex	S. ty of MD.	Medicine	der 1 Year	DA H	D .		NA	/Ct-1
ineral rector	415-30-3488 Usual Residence of Decedent	7. Age (m yrs. 13	Yrs. Month		Hours Min.	8. Dete of 8 (Month, L	irth Day, Year) 8-1926	9. Birthplace Country)	(Stete or Foreig
N N	10a. State 10b. County	10c. Cit	y, Town or Location	-					Inside City Limit
otor	MD. NA	王	Baltimo	re					un Yas 2□N
dier mat be natified	10s. Street and Number 2615 N. Helm	tool Set	10f. 2	Zip Code	-16		10g. Citizen of		
nera		2. Was Decedent Ever in U	,S. 13. Was Dec		ispanic Origin? (S	pecify Yes or N		ce - American II	ndian,
by	1 Never Married 2 Merried 3 Horizon 4 Divorced	Amed Forces?  1 Myes 2 □ No If Yes, Give Year or Detes:	-	2 No		o Hican, etc.)		ck, White, etc.	K
Be Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Decedent's Us (Give kind of	suel Occupa	ation during most of wo	rking	16b. Kind of B	usiness/Industr	ry
Idmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Mecho				Contin	ental (	CAN
ŏ	17. Father's Name (First, Middle, Last)		14/CC 110			me (First, Middle	le, Maiden Sumar		
To	Tom F	avis							
	19a. Informant's Name/Relationship (Typ		19b. Mailing Addre				MD. 2121		de)
	CHERYL HOWELL/DAU  20a. Method of Disposition	1	1 Z 1 D cation - City or Town, Stete						
	1 Burial 2 □ Cremetion 3 □ Re 4 □ Donation 5 □ Other (Specify)	, MD.							
2008	21. Signature of Funeral Service License	Warton	JAME	S A. I			.H., INC		
	23a. Part Linter the disease, or complice and the part failure. List only on	cations that caused the deat e cause on each line.	h. Do not enter the m	ode of dyin	g, such as cardia	c or respiratory	errest,	Inte	proximete erval Between set and Death
an cal	Immediate Cause (Final	n 1000							
ner	disease or condition resulting in death) a	Mesa	or as a consequence of					1 3	wks
iner				.,				:	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequence o	rf):					
edical E	THE INDRIES EVENTS	Due to (o	r es a consequence o	n-					
	resulting in death) Last								
clan								İ	
hysi	Part II. Other significant conditions cont	1		g cause give	en in Pert I.		d tobacco use co ☐ Yes 2 ☐ No		y 4 ☐ Unknow
by P	Teripheral Jas	scular dis	sease				2010		, , , , ,
Completed by Physician/M						24a. We per	es en autopsy formed?	availab	autopsy findings ole prior to etion of cause
mpie								of deat	th?
	25. Was case referred to medical						Yes 2 No	1 □ Y€	es 2 No
o Be Com	examiner?	ospitet:	ER/Outpatient 3	DOA Othe	er: 400 Nursing I		<i>r one)</i> sidence 6 □Otl	her (Specify)	
lon: To	27. Manner of Death 1 SNetural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun		Y	e how injury occu		
catio	2 Accident investigation 3 Suicide 6 Could not be		М	10	Yes 2□No				
Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, term, street, fect y)	ory, office			(Street and Num own, Stete)	ver or Hural Ro	oute Number,
completaly filled in	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	iclan: To the best of my kno er: On the basis of examine and manner stated.	wiedge, deeth occurre tion and/or investigation	ed et the tirr on, in my op	ne, date and place pinion, death occu	e, end due to the	e cause(s) end m e, date and place,	anner es stated and due to the	d. cause(s)
ф	29b. Signature and title of certifier		2	29c. License	e number		29d. Date signe	ed (Month, Day	, Year)
KI	· CPmetoda mas			03	4974		Feb Z	3 2	000
, ( ,	30. Name and address of person who cor	mpleted cause of deeth (Item	7. (load	leaf	Cf # 2	24 col	embia M	7 210	45



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death AMEND#1 PER MD. G780 2-25=2000 JAB Rea. No. 1. Decedent's Nema (First, Middla, Last) 3. Time of Death 2. Data of Death Month Day Year **Physician** LILLIAN FOSTER 7.15 Am FEBRUARY 18 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine BALTIMORE AGNES HOSP If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Deys 1 M 2 F Director 215-09-5969 V.A Usual Residence of Decedan the Menyland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Nems 23s or 28s-f shore the Medical Examiner must be notified at TY Yas 2 No Directo Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 North Gilmor Street U . S . A .

14. Raca - American Indian, death Funeral 21217 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. Yas 2 No Yas, Give 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify. P 3€ Widowed 4 □ Divorced Year or Datas: Black Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry filed within 7 Hygiene. Dept. of Services Elementery/Secondery (0-12) Cottega (1-4or 5+) Services. Foster Mother 8th grade na other permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked othe any Injury or other traumatic event blics. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Ida Asbell Frank McGreer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 21244 Baltimore Md 3419 Milford Mill Road, Hilda Bouldin-Daughter 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Data Puriat 2 ☐ Cremation 3 ☐ Ramovat from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2-22-00 Randallstown, Md King Memorial Park 21. Signature of Furthral Service L 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore Md Part 1. Egfar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final ACPIRATION PNEUMONIA disaesa or condition rasulting in death) Examiner Examiner DEMENTIA physician end s the burial-trans Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last Dua to (or as a consequenca of): Physician/Medical Dua to (or as a consequence of): for use as signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? hes page 2 2 No 1 ☐ Yas 2 ☐ No 1 Yas 25. Was casa relayed to medical examiner? Be 26. Placa of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 0 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 Neturel death. 1 Yas 2 No 2 Accidant after death Director: 6 Could not be datarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Piaca of Injury - At homa, farm, street, factory, offica building, atc. (Specify) filled in by 4 Homlcide

of Vital Records, Division

**DHMH 16 Rev 6/95** 

Hospital 24 hours

within 2

State Registrar

Medical

31. Data filed (Month, Day, Year) FEB 2 5 2000

29a. Cartifian

(Check only one)

29b. Signature and title of cartifier

30. Nama and addrass of person who

32. Registrar's Signatura

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, deta end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

P13602

29d. Data signed (Month, Day, Year)

PATAPS CO AVE 28 BALTIMORE MD21230

2000

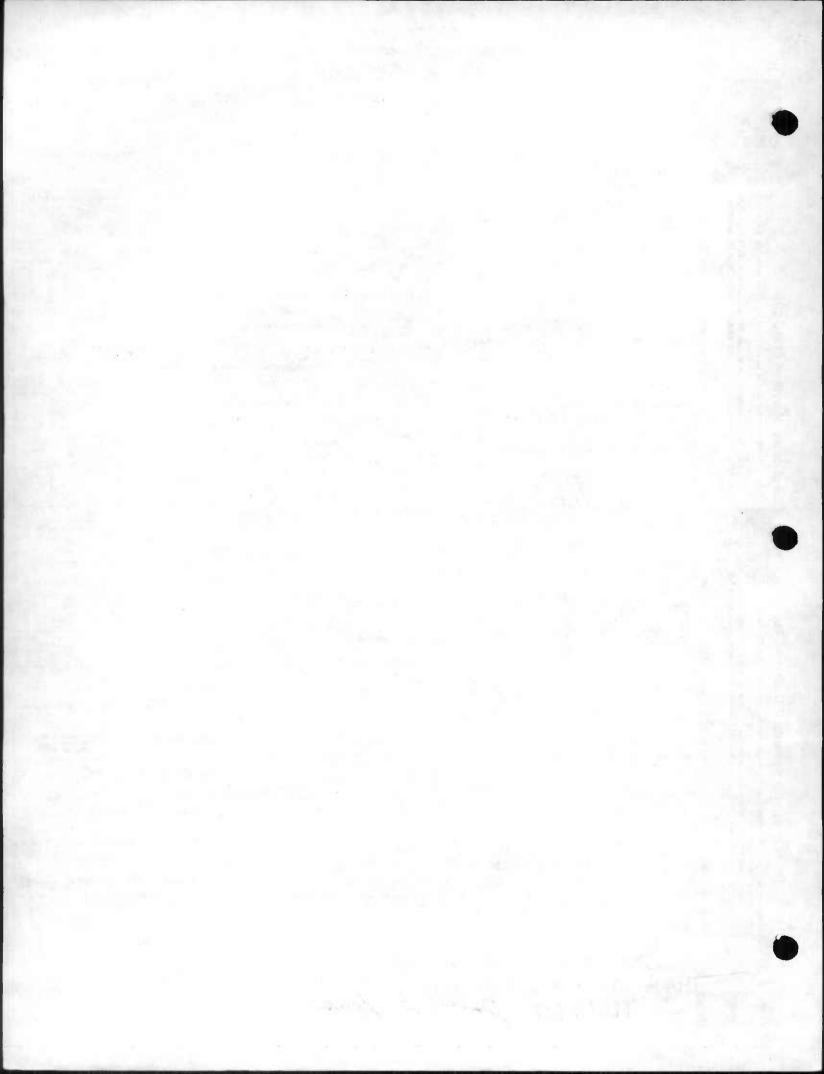
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MAN				Certifica	ate of	Death	,	Reg. No.	<i>J</i> U I	0102				
Physician	1. Decedent's Name (First, Middle, L						2. Date of Dea Month	th Day						
/Medical	KAREN		١.	FRI	EDMAN		FEBRUAI			11:50 AM				
Examiner	4a Facility Name (If not institution, g						Location of Death							
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urs after des st, or lisers Examiner in by Funer	11. Marital Stetus  1 Never Merried 2 Married  3 Widowed 4 X Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:			cedent of F becify Cub 2][] No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American In Black, White, etc. Specify: WHIT		lc.				
ed within 72 ho ypiene. ser than "natum 4, the Medical. Completed	15. Decedent's I	Education rade completed)	168	Decedent's U: (Give kind of	vork done	during most of wi	f working 16b. Kind of Business/Industry			istry				
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Mental H srked of atte ever	DAVID		ACKERMA	AN		FLOREN				ERMAN				
M M M	19a. Interment's Neme/Relationship	(Type, Print)	191	b. Mailing Addre	ss (Street	and Number or F	Iurai Route Numbe	r, City or Town,						
27.	HOWARD FRIEDMA	N / EX-HUSB	AND	9 KILLA	LA CO	URT - TI	MONIUM,	MD 2109						
or oth	20e. Method of Disposition	Removal from State	20b. Place Comete	of Disposition (A	lame of r other ple	ce)	Date	20c. Location -	cation - City or Town, State					
ment ment manual			HILLTY	OP SERV	CE C	ORP.	2/24/00	TOWSOL	N, MD					
Depart Import any in	1 Buriel 2XX remation 3 Removal from State 4 Donetion 5 Other (Specify)  HILLTOP SERVICE CORP. 2/24/00 TOWSON, MD  21 Signature Funeral Service Licensee  22 Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD — PIKESVILLE, MD 21208													
/Medical Examiner  Examiner  Examiner	Immediate Cause (Fine) disease or condition resulting in death)  Due to (or es e consequence of):													
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	Due to (or es a	consequence of	f):					1				
5 00 _	thet initiated events resulting in death) Last													
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Direction of the property of t	4 ☐ Homicide determine	building, etc.		GAMA			28f. Location (S City or Tow	m, Stete)	. DO	BRITUDIEN				
within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification.	29e. Certifier 1 Certifying P (Check only one) 27 Medical Exs	hysician: To the best of miner: On the basis of e	my knowledge examinetion ar	e, death occurre	d et the ti	me, date end place	e, end due to the	ause(s) and ma	anner as sta	ited.				
within 24 hours within 24 hours to the Funeral completely filled	29b. Signature and title of certifier	and menner stet		2	9c. Licens	e number		29d. Date signe	d (Month, D	Pay, Year)				
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4	30. Name end address of person who	completed cause of de			٠, ٢٠٠	not D-7	<b>L</b> i	for-1	2 2120	\1				
0	31. Dete filed (Month, Dey Year)	32. Registre		Z Penr	str	eet, Bal	timore, 1	narytano	1 2120	)1				
State Registrar	FEB 2 5 2	000	The state of	D A	oork	2								

DHMH 16 Ray 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death <sup>Day</sup>2000 Month Feb. **Physician** Bonnie C. Gilchrist 22, 11:45pm /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Genesis Elder Care Brookland Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthpiaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖾 F 89 Yes 226-01-5965 Virginia Director 1910 Usual Rasidance of Decedent with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at Baltimore Highlands MD Baltimore 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 21227 2908 Florida Ave. Funeral death 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacadani Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No tf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours eiter Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturel; or ite any injury or other traumatic avent, in a vedical Examina. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married White 3altimore, Maryland 21215-0020 1 Yas 2X No Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Electronics Industry Clerk 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Surnama) Crettie Furrow Luther Barbour 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2927 Florida Ave. Baltimore Highlands, MD. 21227 June Jackson, daughter 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City or Town, State Burial 2 Cramation 3 Ramoval from Stata 02-26-00 Baltimore, MD Loudon Park Cemetery 400 onation 5 Othar (Spacify) 22. Nama and Addrass of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. eny li 21227 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Batwean Onset and Death **Physician** Immediata Causa (Final disaesa or condition resulting in death) /Medical Examiner Gilchrist, Bonnie Dua to (or as a consequence) Examiner ician end bunal-transit Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) eabelo physician Physician/Medical the Dua to (or as a consequance of): 88 the attending USB for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings availabla prior to complation of cause of daath? Completed 24a. Was an autopsy 1 ☐ Yas 2 No 1 □ Yas 2 □ No Be 25. Was casa referred to medical axaminar? 26. Place of Beath (Check only ona) 1 Yes 2 No Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division 1 Natural 5 Panding invastigation or Attendination after death. 1 □ Yas 2 No 2 Accidant Could not be datarminad 3 Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28e. Plece of tnjury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 Homleida 24 hours e Medical 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, deta and plece, and due to the cause(s) end menner es steted. 2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29a, Cartifian To the Hosp within 24 ho To the Fune completely fi (Check only one)

State Registrar

31. Dela filad (Month, Day, Year) FEB 2 5

29b. Signatura and titla of certifiar

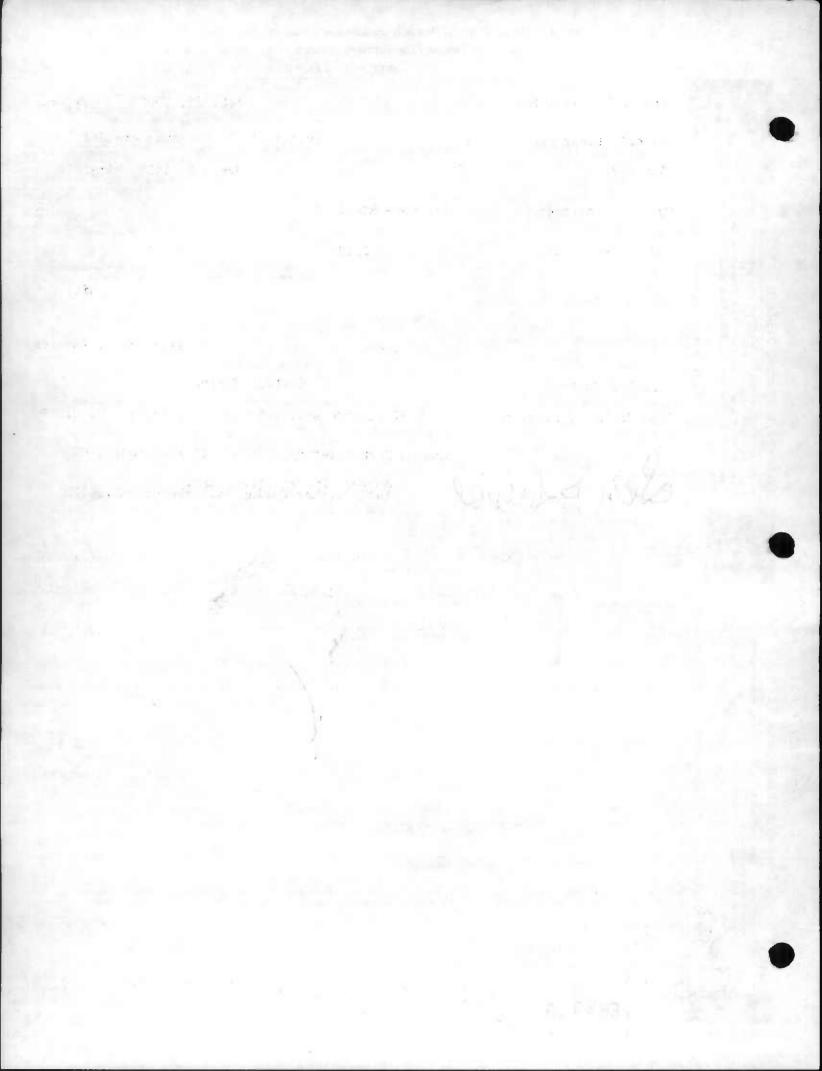
Ragistrar's Signatura

29d. Data signed (Month, Day, Year)

Caupmen 30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print)

Baltimore MD 21227 POPLIS S. KARIPINENI 24000 AND A POPL

29c. Licansa number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#8 perFH G780 2/25/2000 EW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:30A.H Kenneth Gresham 31, January 2000 /Medical 4a Facility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins HOSDI Hours Min. Mooth, D If Under 1 Year 8. Date of Birth Month, Day, Year) 953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days ufikilown 1XM 2□ F 46 Yrs Director 577-74-2188 Usuel Residence of Decedant 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits in then "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Unken OWNO Director unknown unknown unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unknown unknown unknown deeth 1 Funeral 12. Wes Decedent Ever in U,S Armed Forcas? Wes Decedenl of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Bleck, White, etc. 11. Meritel Stelus permit. Peges 1 end 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Throportant: If frem 27 is marked other than "natural", or than any injury or other traumatic event, the Medical Federal Process. 1 □ Yas 2 □ No If Yes, Give Yaer or Dates: unknown 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 2 unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, MD Johns Hopkins Hospital 600 N. Wolfe Street 20b. Plece of Disposition (Nama of 20c. Location - City or Town, Stata 20a, Mathod of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Steta 4 ☐ Donetion 5 🖔 Other (Specify) in state 21. Signature of Funeral Service Licerves Sent State Address Feel Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Intracranial hemorrhag diseese or condition resulting in deeth) Examiner Examiner emboli The law requires that the death certificate be executed ding physician end use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Dua to (or as e consequence of): Bacterial Endocarditi Physician/Medical Due to (or es e consequence of): illicit Intravenous Substance Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yaa 2 ☑ No 3 Probably 4 Unknown p 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yas 2 ☑ No 1. Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Naturel s after death. 1 Yas 2 No 2 Accidant

Box 68760, P.O. Records, Division of Vital

Baltimore, Maryland 21215-0020

6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 29e. Cartifiar 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end dua to tha cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) end manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year) January 30, 2000

State

stely filled in by

29b. Signeture end title of certifier

ndreal Con MDPhD

24 hours the Hospital

To the Complet

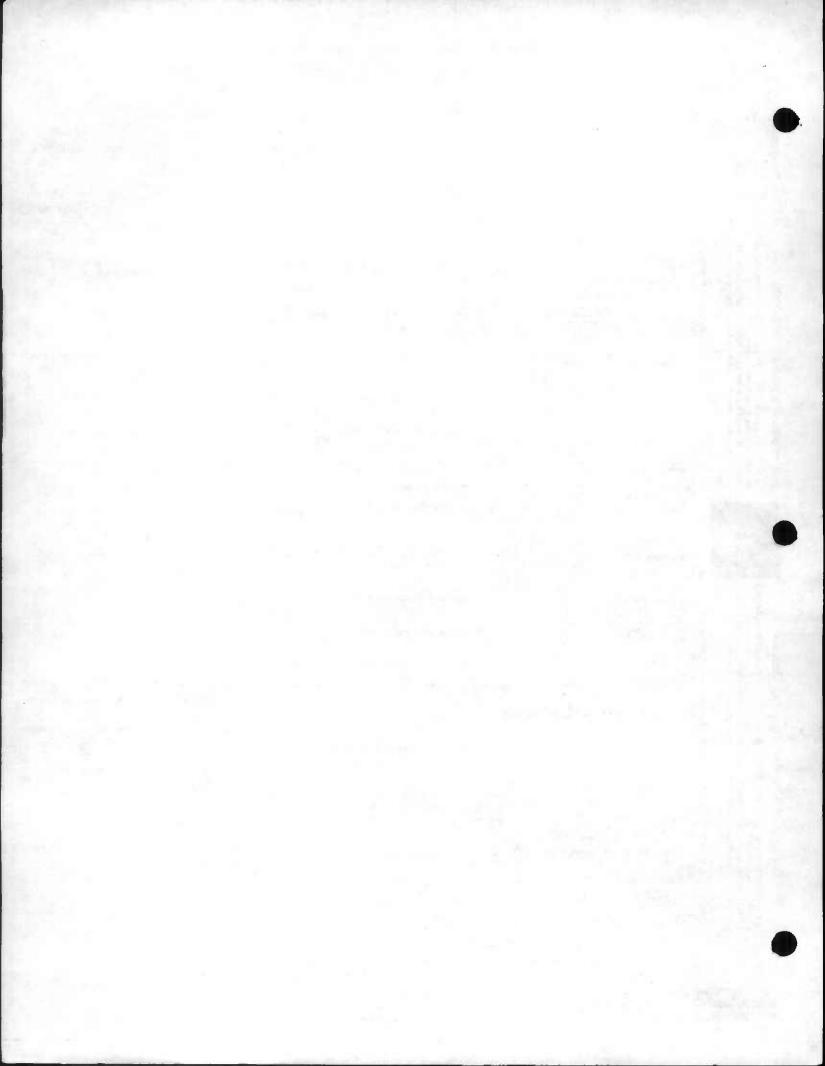
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Andrea L. Cox MDPhD Caroline Street Battimore, MD 21287 601 North 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) 25

Registrar



### Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JEROME (	GAR				of Ma	ryland		artment of F tificate of	Health and I Death	Mental Hy	/giene [] ( Reg. No.	0 0	6105
Physic		1. Decedent's Nam	e (First, Middle, La		cvin					2. Date of D Month FEB	Day 19, 20	Year	3. Time of Death
/Med Exami		4a Facility Name (	If not institution, given	e street and n	umber)				4b. City, Town, or BALTIMOR	Location of Dea			1103.60 111
Funera Director	_	5. Social Security N	Number 6. 9	Sex 1 M 2 F		(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth lay, Year) 14-54		ace (State or Foreign hy) MD
yland	П	Usual Residence o 10a. State	10b. County			10c. City, T	own or Lo	cation				10	Od. Inside City Limits
e Mar	Director	MD	NA			Bal	timo	re					1 Yes 2 No
with th		10e. Street and Nu	mber atthews	Chan				10f. Zip Code 21218			10g. Citizen of		lry?
5-0020 72 hours after death with the Manyland natural; or Herns 23s or 28s-f ahow natural is notified at	by Funeral	11. Marital Status	ied 2□ Married	12. Was De Armed F 1  Yes If Yes, G	cedent Ex- Forces? 2 X No		,	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	to Rican, etc.) Black, W			
5-002 72 hours	Completed b	3 LI Widowed	15. Decedent's E	Year or ducation	Dates:	1	6a. Deced	lent's Usual Occup	pation	16b. Kind of Business/Industry			
d within glene.		(Special Special Speci			() (1-4or 5+	)	life. I	kind of work done OO NOT use retire	during most of word)	Sanitation Dept.			
Maryland 2 d 2 should be filed th and Mental Hygin T is marked other traumatic event, it	9	200000000000000000000000000000000000000	(First, Middle, Last	)					18. Mother's Nar	141	e, Maiden Sumar	me)	
should be nd Mental marked o	To	Otis	M ame/Relationship	ack			10h Mailin	on Address (Street	Stella Mae Garvin ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2				
E = 0 F		Renee	Malon						Street				
0 % 5 = 5			position Cremation 3 [ 5 Other (Special		n State	com	atany coan	sition (Name of natory or other pla Mem. G	ardens	Date 02-25-	20c. Location 2000 D		
Baltim pemit. Pag Department important: any Injury once.		21. Signature of Fi		re, Ma	_	nd 21202 enue							
(68760, Medicale be executed Examiner of physician and set the burist-transit	dicai Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, nmediate srlying injury	b	D	Due to (or as	s a conseq	uence of):	ar Disea	ie		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
hat the death certificed by the attending p	Physician/Me	Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use co										ontribute to	
Cords,	Completed by P	LARY	IGEAL CA			24a. Wa	s an autopsy formed?	24b. We	re autopsy tindings illable prior to inpletion of cause leath?				
	ошо									1180	Yes 2 No		Yes 2□ No
	Bec	25. Was case reference	red to medical						26. Place of Dec	ath (Check only	one)		
of Vita Physician: this certific ral director,	10	₩ÖYes 2□				XX ER		I SLI DOA			sidence 6 Ot		)
ion inding ath. r: Affar	Certification:	27. Manner of Deat  1 Natural  2 □ Accident  3 □ Suicide	5 Pending investigatio	n	nth, Day	Year)	tnjury	M 1	ryat rk?  Yes 2 □ No		how injury occu (Street and Num		I Paula Number
DIVISION Attended at a ster death of Director:	Certif	4 Homicide	determined	build build	ding, etc.	(Specify)	s, ramii, Sur	eet, factory, office			own, State)	our or riors	Thouse trained;
DIVIS To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edicai	29a. Certifier (Check only one)		niner: On the		examinetion			me, date and place opinion, death occu				
To the	Σ	29b. Signature and	title of certifier	n. 0	4			29c. Licens	c.M.E		29d. Date signe FEB.		Day, Year) 2000
1)		30. Name and addr	M. THUS	completed cau	use of dea				, Baltimo	re, Mar	yland 2	1201	
St Regist	ate rar	31. Date filed (Mon FEB	2 5 2000		Registrar	's Signature		love					



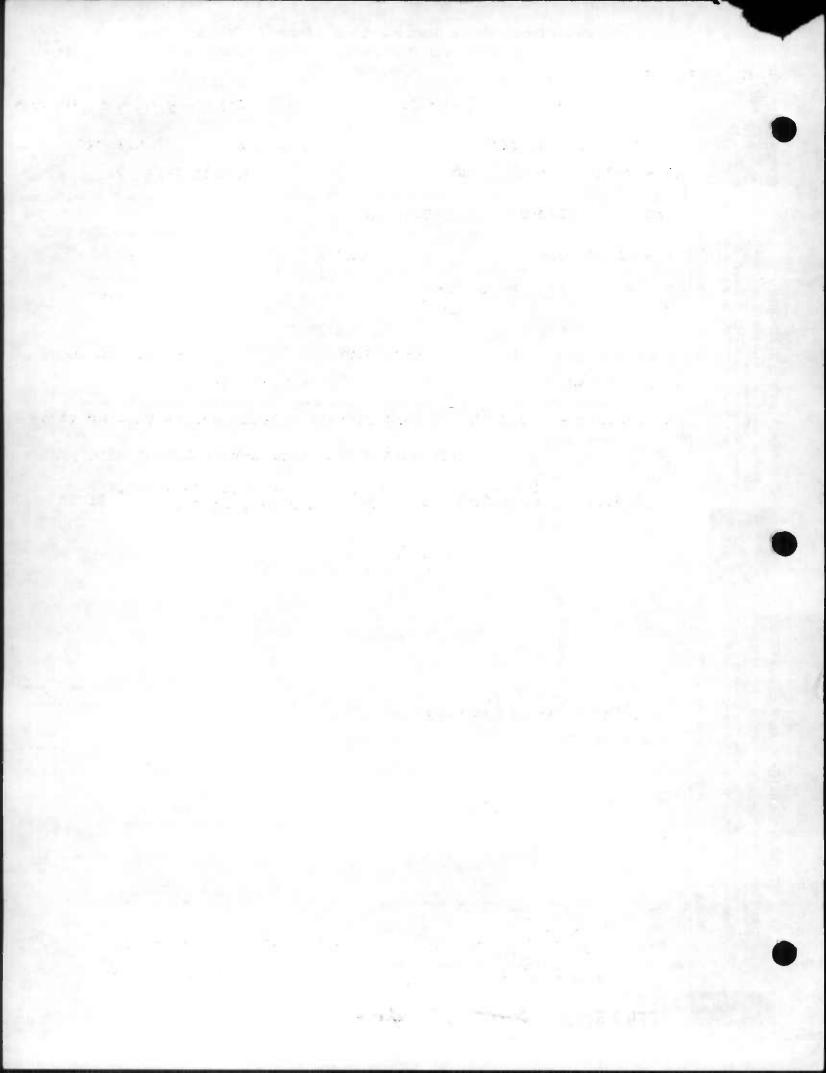
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#19a PER F.H.. G780 2-25-2000 JAB 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death 22, Year 2000 Month **Physician** GLENN PULLIS W: 48 Pa PEBRUARY /Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner NORTHWEST HOSPITAL BALTIMORE
If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Social Security Number **Funeral** Months Days 1 M 2 F Yrs. 226-12-9277 80 Director APR. 5 1919 VA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location r 28a-f ahow 10b. County 10d. Inside City Limits MD BALTIMORE CATONSVILLE 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number "naturel", or items 23s or 4 WINESAP COURT 21228 USA Pages 1 and 2 should be filed within 72 hours after death nearl of Mantal Hygiena.
nnt: if item 27 is marked other than "naturel", or items 23 ury or other traumatic avent, in Medical Engines man in your Funeral 12. Was Decadant Ever in U.S. Armed Forces?

DOWes 2 No 10-43
If Yes, Giva
Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Raca - Americen Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: BLACK p 3 ₩ Widowed 4 Divorced 8-45 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST 8th NA BETH. STEEL 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumeme) Be JOSEPH GLENN HATTIE FOWLKES WATSON 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HAZEL HAZEL — DAUGHTER 1334 PLEASANT VALLEY DR. BALTO., MD 21228 20b. Place of Disposition (Nama of cernatary, crametory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if eny injury or GARRISON FOREST VETERANS 2-29-00 OWINGS MILLS, MD of Funeral Sarvice Licensea 22. Nama and Address of Facility MARCH FUNERAL HOME WEST, INC. Enter the diverse, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, and the list only one causa on each line. 21215 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting In death) estud fear Pailud Examiner Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Records, P.O. Box 68760, certificate be Physician/Medical Due to (or as a consequence of) 60 USB Part II. Other significant conditions contributing to death but not resulting in the undarlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown neuwoung signed t Aq 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital I or Attending Physician: 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 this 28a. Date of Injury (Month, Dey Year) funeral 27. Manper of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: After 5 Pending invastigation 1 Natural oftar death. Director: Aft 1 Yes 2 No 2 ☐ Accident 6 Could not be datamined 3 ☐ Suicide 28f. Location (Streat end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month. Dav. Year) Theak ma itad causa of death (Item 23a) (Type, Print) IMPERIAL NWAC 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 2 5 2000



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:05 ELIZABETH BATTS

Va

XX Yes 2 No

Approximate Intervel Between Onset end Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Tz nualles

**Physician** /Medical Examiner

**Funeral** 

the Maryland 28m-f ŏ

therm 23s or 72 hours after the Medical Exami Hygiene.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

sician and burial-transit physician the burial Box 68760. for use P.O. Division of Vital Records. or Attending Physicien: this After n 24 hours after death.

The Funeral Director: After the full of t

FERRUARY WY, 2000 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1□M XXF 84 226-22-6655 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6805 Carl Avenue 21207 US A Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married specity: Black 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Homes Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Meath and Mental Higher Importants if Item 27 is marked other the any Injury or other traumatic event, the other. 5th grade Domestic Worker 17. Father's Neme (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumeme) Be Thomas Stith Helen Hicks 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6805 Carl Avenue Balto, Md 21207 Elaine Paysour-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Staton Memorial Cemetery 2-28-00 Scotland Neck, N.C. 22. Name and Address of Facility
March F/H West 21. Signeture of Fuperal Service Licenses Wabash Avenue Baltimore, Md 4300 23al-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) UROSEPSIS Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 PNo 1 ☐ Yes 1 Tyes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No

State Registrar

edical

31. Date filed (Month, Day, Year) FFR 2 5 2000

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Nama and address

29b. Signature and title of

6 Could not be determined

32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

(MPERINZ

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

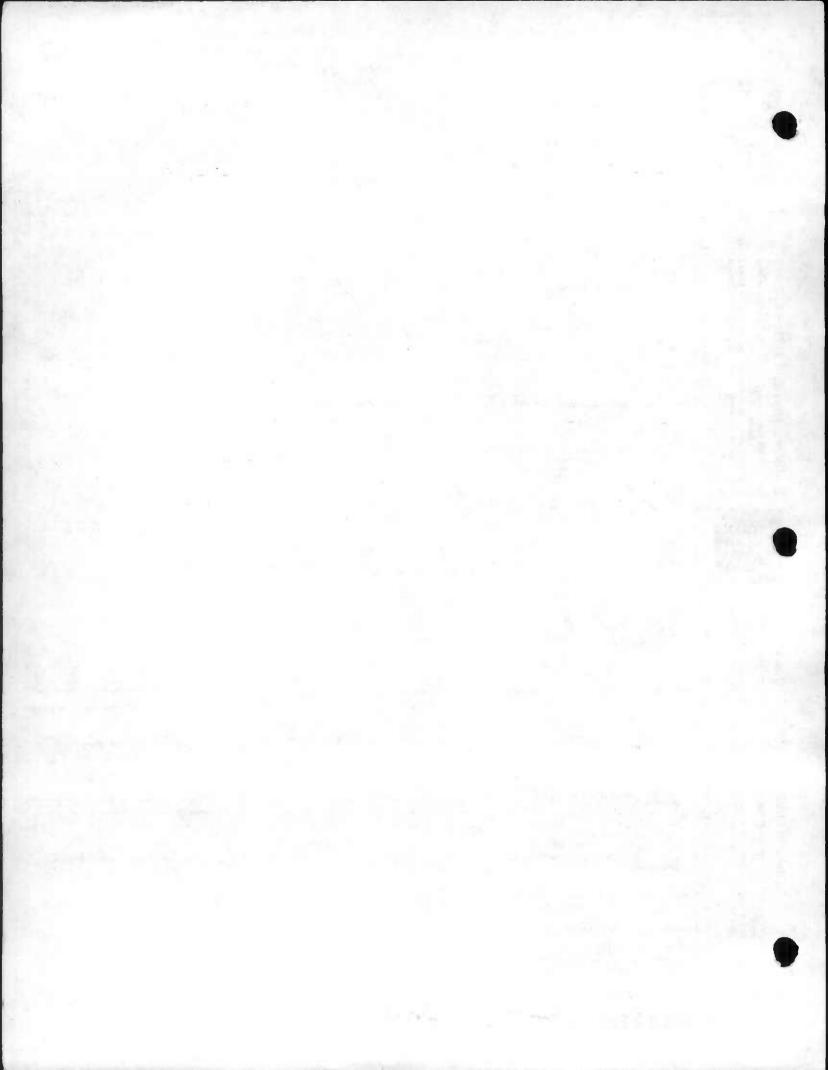
Hospital

within 2 To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.



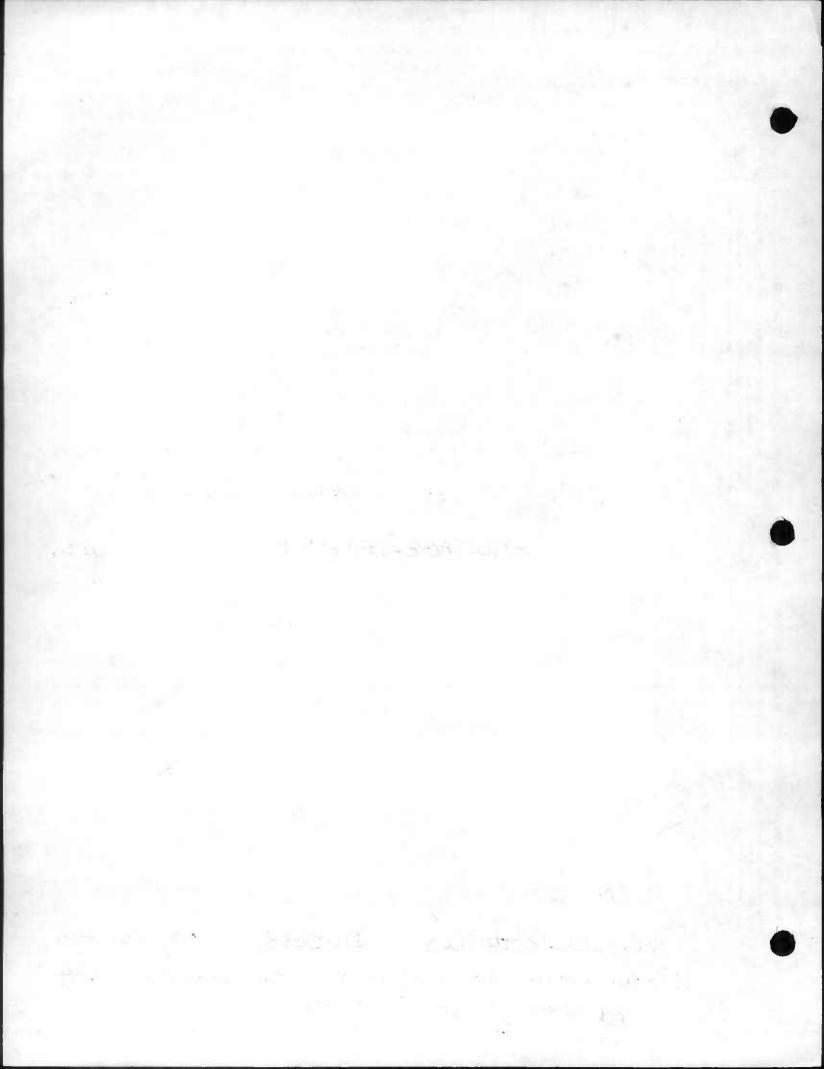
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LILLIAN BRADY GERDING 23, 2000 February 7:20AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakcrest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14, 1908 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Mary land Yrs. 214-24-9148 Director Gerding, Lillian Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Baltimore Parkville 10e. Streef and Number 10f. Zio Code 10g. Citizen of What Country? 8832 Walther Blvd. 21234 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes AZNo if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes XX No Specify: Maryland 21215-002( Specify: XX Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic avent, the Mental Injury or other traumatic avent. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John T Brady Jr Lillie E Resch P 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Donald Gerding Son 335 Old Trail Baltimore, Maryland 21212 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Jurial 2 Cremation 3 Removel from State 2000 2/26/00 Oaklawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Lice 22. Neme end Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner 7:20 AM Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): attending physician for use as the bune Due to (or as a consequence of): signed by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital I or Attending Physician: after death.
Director: After this certifica 25. Was case referred to medical 26. Placa of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours at To the Funeral D completely filled Hospital edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier å 29b. Signature end fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 ause of death (Item 23a) (Type, Print) Bultimore MD 21234 8800 Worther 32. Registrar's Signature State 25

Registrar

-33-

03



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#19A PER INFMNT & F.H. G783 5-22-200 Jertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 22, 2000 510 am rebrusky EDITH HEARD 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) XIOSP: tal faltimore Jaryland (reneral N/A If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1□M 201€ 89 Yrs. 220-14-5125 JUNE 16 1910 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XXes 2 □ No MARYLAND N/A BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A. 727 DRUID PARK LAKE DR. 4D 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 ☒ Xo if Yes, Give Yeer or Detes: 1 Never Merried 2 Married Specify: Specify: 3 ₩ Vidowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11th DOMESTIC PRIVATE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) RANDOLPH NICHOLS MARY LOU ALBROOKS 19e. Informent's Name/Reletionship (Type, Print)
MARJORIE D. BANTON/
Margie D. Banton/Sister DAICH 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 717 Druid Park Lake Dr., #401, Baltimore, Maryland DAUGHTER 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 17 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) ARUBUTUS MEMORIAL 2-28-00 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Lippy 22. Name and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 202 1206 W NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Arute Myocardial Due to for es e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es e consequence of): Due to (or as e consequence of): resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending Investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier (Check only one)

Examiner certificate be execu 68760 P.0. Records. of Vital Division or Attending s after death.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Mantal Mantal

opartment of Health and 2 sh, important if Health and h important if Health is man any Injury or other.

**Physician** 

/Medical

attending physician and for use as the burial-transit

the 3

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director

funeral

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After

Director

Funeral

by

Completed

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Examiner

Physician/Medical

by

Completed

Be

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Certification:

To the Hospital o within 24 hours at To the Funeral Di completely filled is Medical Registrar

State

Prabhakar,

29b. Signeture end title of certifier

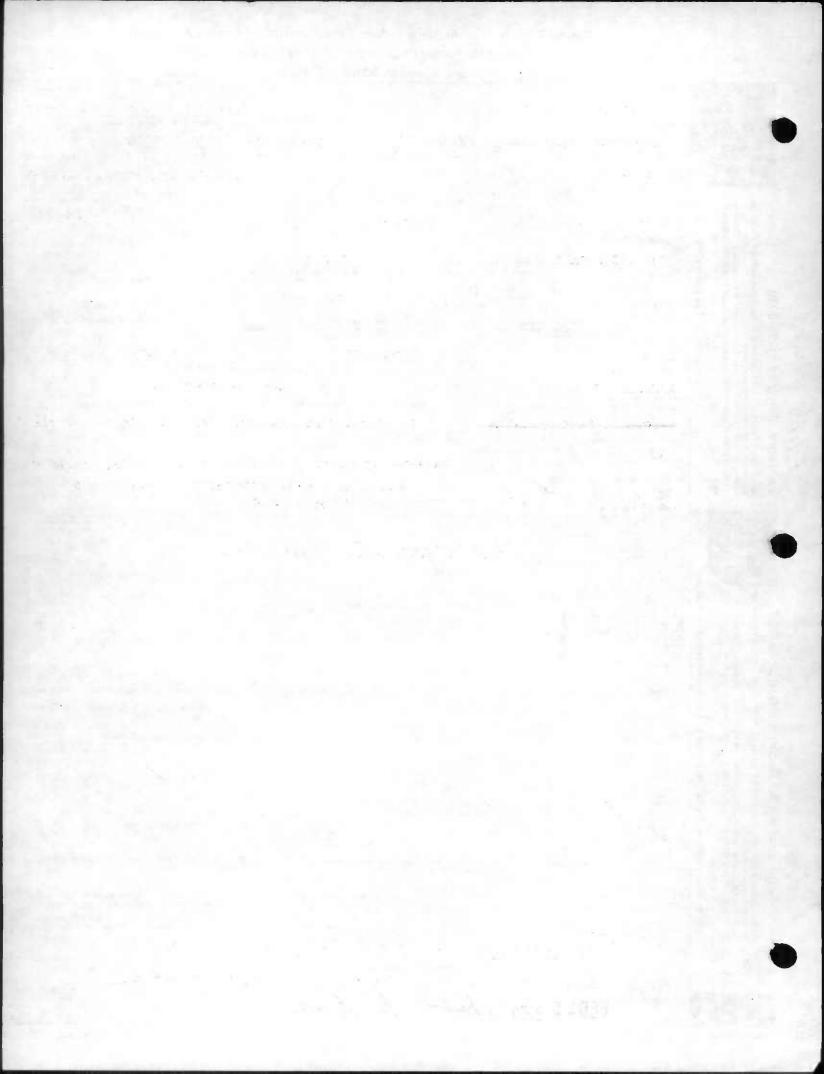
32. Registyar's Signeture 2000

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Maryland General Hospital

29c. License number

29d. Dete signed (Month, Dey, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Day Holmes 13:30 Carrol February 24 2000 4a Facility Name (If ngt institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death/ 0 Inder 24 Hrs. 8. Date of Birth (Month, Day, Year) If Linder 1 7. Age (In yrs. last birthday) Security Number Birthplace (State or Foreign Country) Months Days Hours 1**X** M 2□ F 216-01-8264 85 07/24/1914 Balto. Md. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ¥ Yes 2 □ No Baltimore Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 3669 Hineline Road, 21229 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11 Marital Status Black, White, etc. 1 MYes 2 No if Yes, Give Year or Detes: 1 Never Merried 2M Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Supervisor Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme Carroll E. Holmes Carrie Wehrmann 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frances Holmes (Wife) 3669 Hineline Rd., Baltimore, Md. 21229 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Loudon Park Cemetery 2/24/00 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Serving License Ambrose Funeral Home of Lansdowne 23a. Pert1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) ha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Small Boul Resection 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 2E No 1 Yes 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of after death Director:

**DHMH 16 Ray 6/95** 

within 24 hours a To the Funeral D

State Registrar

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

with the Maryland

death

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "eny Injury or other treumatic event, the Mes

**Physician** /Medical

Examiner

8

Physician/Medical

à

Completed

Be

2

Certification:

Medical

#

3altimore, Maryland 21215-0020

31. Date filed (Month, Dey, Year) FEB25

29b. Signature end title of certifier

29e. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year) February 21, 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Coltonon MD 21229

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

Michael Gallagher 900 Coston

32. Registrer's Signeture

111 A



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** )1:15AN RSC F 2000 2 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1/timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Deys 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** # M 2□ F Deys 220-24-6601 70 Yrs Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits me 23e or 28e-f ahor Md. N/A Director 1 TYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 N. Monroe St. Norms 23a 21215 U.S.A. Funerel 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 N Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 → Merried altimore, Maryland 21215-0020 neturel', or Black 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene. Important: If Itam 27 is marked other than 'n eny Injury or other treumatic event, the Heal place. Self-Employed Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christopher C. Horsey Mazie Horsey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BRENDA HORSEY 819 N. Monroe St, Baltimore, Md 21217 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from Stete GarrisonForrest Ceme 02-29-00 4 □ Donetion 5 □ Other (Specify) Owings Mills, Md. 21. Signature of Funeral S 22. Name end Address of Facility Howell Funeral Home 4600 Liberty Hghts.Ave.Balto.Md.21207 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical ACCIDENT (CUA CEREBRO - VASCULAR Examiner ERTEN The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Physicien/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Were eutopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Vital Attending Physician: Be 25. Was case referred to medical 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) T⊠Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Division 1 Natural 24 hours after death. 2 Accident 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dale and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicel 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anes 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Daeth HOPKINS 14 19 2000 BESS18 FEBRUARY 10:45 PM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) Altimore If Under 24 Hrs. 8. Dete of Birth 6. Sek If Under 1 Yeer 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdey) 217-48-782 Usuel Rasidance of Decedent Months Deys Yrs. 10a. State 10b. Co 10c. City, Town or Location 10d. Inside City Limits/ 1 Yes 2 No 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 2/2/ 14. Race -Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) American Indien. 11. Meritel Stetus Black, Whita, atc Yes 2 No f Yes, Give feer or Detes: 1 Never Merried 2 Merried 1□Yes 2□No Specify 3 Widowed 4 □ Divorced 18e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired); 16b. Kind of Business/Industry 15. Decedent's Education Flamentary/Secondary (0-12) College (1-4or 5+) 12th 18 Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Name (First Middle, er-John 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Streat end Number of Rurel Routs, Number, City or Town, Stete, Zip Goog, 20b. Plece of Disposition (Ne Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremation 3 Remo 5 Other (Specify) 4 Donetion 21. Signature of Funeral Sa 22. Name end Address of Fecility Do not enter the mode of dying, such es cardiec or respiretory errest, 23a. Part1. Enter the disees shock, or heart failure. Immediete Ceuse (Finel diseese or condition resulting In deeth) 1-18 ART FAILURE CONGESTIVE Dua to (or as e consequence of) SEVERE ADRTIC STENOSIS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in daeth) Last Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. 24b. Ware autopsy findings eveilebla prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 70 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how Injury occurred

**Physician** /Medical Examiner Examiner

**Physician** 

Examiner

**Funeral** 

**Director** 

the Maryler

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Heelth end Mental Hygiene. Important: If Item 27 is marked networks.

7 is marked other than "naturel", or flems 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

/Medical

Directo

by Funeral

Completed

Be

physician end the burial-transit that the death certificate be executed USB BS ed by the e pega 2 s certificate this

Physician/Medicai

Completed

Be

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Certification:

edicai

Attending Physician: funerel oftar deet ò filled in I 0 within 24 hours

Division of Vital Records, P.O. Box 68760,

25. Was case rafarred to medical examinar? 1 Yes 2 No

1 Maturel

2 Accident

3 Suicide

4 Homicida

5 Pending investigation 6 ☐ Could not be datermined 28a. Date of Injury (Month, Dey Year)

28b. Time of 28a. Place of Injury - At homa, farm, straet, fectory, offica building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at tha time, data and place, end due to the causa(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. (Check only one) 29c. License number

29b. Signeture and the of certifier

D 42723

29d. Dete signed (Month, Day, Year) FEBRUARY 23RD 2000

30. Neme end eddrass of person who completed cause of death (Item 23a) (Type, Print) M HARISH . AVYERAHALLI

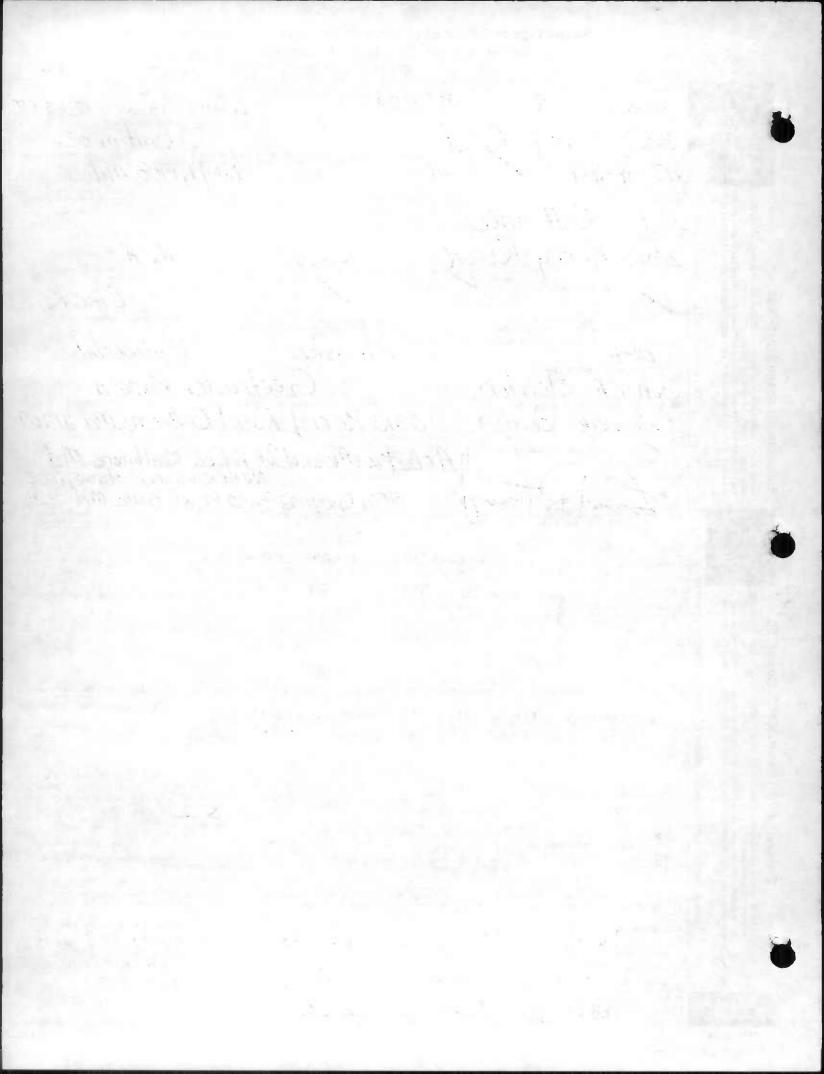
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Registrar

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31. Dete filed (Month, Dey, Year) FEB 2 5

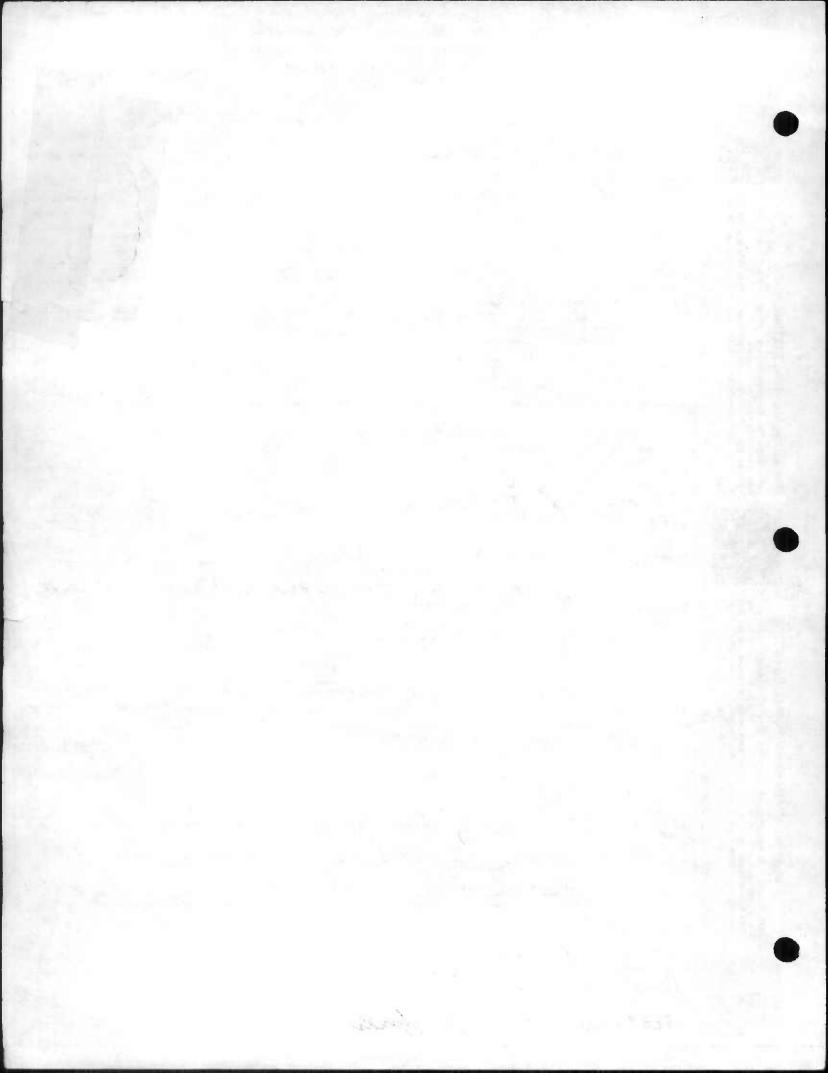
32. Registrer's Signature



00-1009-00 B.K.S	Piea	se Type or Pri		k Indeiibie in Department of				ble.					
TERANCE HE	REGARMS: #1 PER ME			Certificate o		, ,	g. No.	06113					
	Decedent's Name (First, Middle	o, Last)	*****			2. Date of Deat Month		3. Time of Death					
Physician /Medical	Terrance		Henega	n		FEB.	20, 200						
Examiner	4a Facility Name (If not institution				4b. City, Town, or L	ocation of Death	4c. County	of Death					
	FRANKLIN SQUAR  5. Social Security Number		e (In yrs. last bir	thday) If Under 1 Yes	ESSEX ar If Under 24 Hrs.	8. Date of Birth	BALT	IMORE					
Funeral Director	092-52-0477	NEM 2□F		Yrs. Months Day		(Month, Day,		Birthplace (State or Foreign Country)					
	Usual Residence of Decedent					03-09	-64	NY					
anyler show	10a. State 10b. County		10c. City, Tow					10d. Inside City Limits					
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deeth with the Maryland ma 23a or 28a-f ehow Liniat be notified at	1 Sun Court			212			US.	What Country?					
re 23s	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent o	f Hispanic Origin? (So	ecify Yes or No-	14. Rac	e - American Indian,					
	1 ☑ Never Married 2 ☐ Men	Armed Forces?  1 Yes 2 21  If Yes, Give		If Yes, specify Cu	ıban, Mexican, Puerto	Rican, etc.)	100	ck, Wibite, etc.					
5 F. S	3 Widowed 4 Divorced	Year or Dates:		10 165 201	о зресну.		Speciny	Black					
ed within 72 ho ygiene. er then "neturn t, m te deal Completed	15. Deceden (Specify only higher	's Education t grade completed)	16a.	Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	e during most of work	ring	16b. Kind of B	usiness/Industry					
within then.	Elementary/Secondary (0-12) 12th Grade	College (1-4or :		ssembly									
ETES .	17. Father's Name (First, Middle,			ssembly	18. Mother's Nam	e (First, Middle, A	Genera Maiden Suman	al Motors Co					
should be and Mentel marked of martic ev	John A.	Henegan			Sylvia	a S	lade						
2 should and Man ie marke eumatic	19a. Informant's Name/Relations	nip (Type, Print)	196	. Mailing Address (Stre	et and Number or Rur			State, Zip Code)					
s 1 and 2 should I Health and Mar tem 27 le marke other treumatic	Sonya Her	egan	1	Sun Court	t Baltimo	ore, Ma	ryland	21221					
902 5	20a. Method of Disposition  10 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of commetery, crematory or other place)  Kensico Cemetery 02 -25-2000 Mt. Pleasant, N												
permit. Peges Department of Introducer if its Proportant: if its Proportant: or	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 2120												
o de la companya de l	WM.C.March FH 1101 E. North Avenue												
	23a. Part1. Enter the disease, or complications that ceused the death point enter the mode of dying, such as cardiac or respiretory arrest.  Approximate Interval Between												
Physician													
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· lard	iac	Brythm	12								
5		11 2-1	Due to (or as a	consequence of):	1 h	1, 1.2.	/	ur disease					
acuted end i-transit xaminer	Constant States and States	b. Ityper	Dua to love e e	consequence of):	resona	Winda	rescur	is asserte					
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of the deeth certified by the ettending eteched for use eteched for use Physician/M	Part II. Other significant condition	ns contributing to death b	given in Part t.	23b. Dld to	bacco use co	ntribute to the cause of death?							
and by the deteched				1 🗆 Y	s 2 No	3 Probably 4 Unknow							
: 52 G				24a. Wes a	n autonsv	24b. Were autopsy findings							
The law requir						perform		available prior to completion of cause					
The law ate hes t page 2 s						4/78/		of death?					
certificate rector, per	25. Was cese referred to medica				26 Place of Deat	th (Check only on		14 Yes 2 No					
Physicien: this certific rsi director,	examiner? XXYes 2 No	Hospitat:	ent 2/CXER/Ou	tpatient 3 DOA	Wher:	ome 5 Reside		ner (Specify)					
ding Phy. After thi funeral	27. Manner of Death 1 ØNaturat 5 ☐ Pendin	28a. Date of Inju	4341	Time of 28c. In		28d. Describe ho							
	2 ☐ Accident investi	ation			☐ Yes 2 ☐ No								
tal or Attending P re after deeth. al Director: After t led in by the funen Certification:	3 Suicide 6 Could determ	ned   286. Place of Inj	ury - At home, fa c. (Specify)	rm, street, factory, offic	28f. Location (St City or Town		per or Rural Route Number,						
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he Hospitai in 24 hours he Funeral pletsly filled		Physician: To the best of examiner: On the basis of and mathems shall	examination an										
To the Hospital or Attentwith 24 hours effer deet To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifie	10011	1000	29c. Lice	nse number	2:	9d. Date signe	d (Month, Day, Year)					
P 5 P 0		1/14		0.	C.M.E		FEB. 20, 2000						
10	30. Name and address of person	no completed cause of d	euth (Item 23a)	(Type, Print)									
	David R	Forber	111	Penn Stree	t. Baltimo	re. Mary	land 2	1201					

30. Name and address of person who see August 1997 (Month, Day, Year) State Registrar

32. Registrar's Signature



### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death EMMA FEBRUARY 23, 2000 14:20 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDICAL CENTER BALTIMORE CITY BALTIMORE MERCY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JULY 25, 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 1□M 200 Months BALTI ORE, D. 78 Yrs. 214-14-1655 Usual Residenca of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yas 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 S. HERRING CT. 21231 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas XX No If Yes, Give Yaar or Datas: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: AFRO AMERICAN XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) HOUSE DOMESTIC WORK 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) "ARGARET JOHNSON CHARLES JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GALATIC BRANDFORD 227 S. HERRING CT, BALTIMORE, MARYLAND 21217 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LANSDROWN, ARYLAND MT. ZION CEMETERY 3/1/00 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SER, P. A. 21 Signature of Funeral Service Licenses LLOYD ESTEP 23a. Part. Enter the dide, se, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails or. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weck Dneumonia disease or condition resulting in death) tzeo > 1 month Sequentially list condillons, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yss 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner physician end the buriel-transit signed by t

P.O. Box 68760

Division of Vital

death.

i or Attand after death Director:

To the Hospital o within 24 hours at To the Funeral D completely filled I

**Physician** /Medical

**Physician** 

/Medical

Examiner

Directo

Funeral

by

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Exercises must be notified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medical

P Completed Be 10

PETER LEUCHTMANN

25. Was case referred to medical examinar?

1 Yes 2 No 27. Manner of Death

1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident

6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Ecritifying Phyaician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29b. Signature and sitti∮of centif 29c. Licansa number 29d. Date signed (Month, Day, Year)

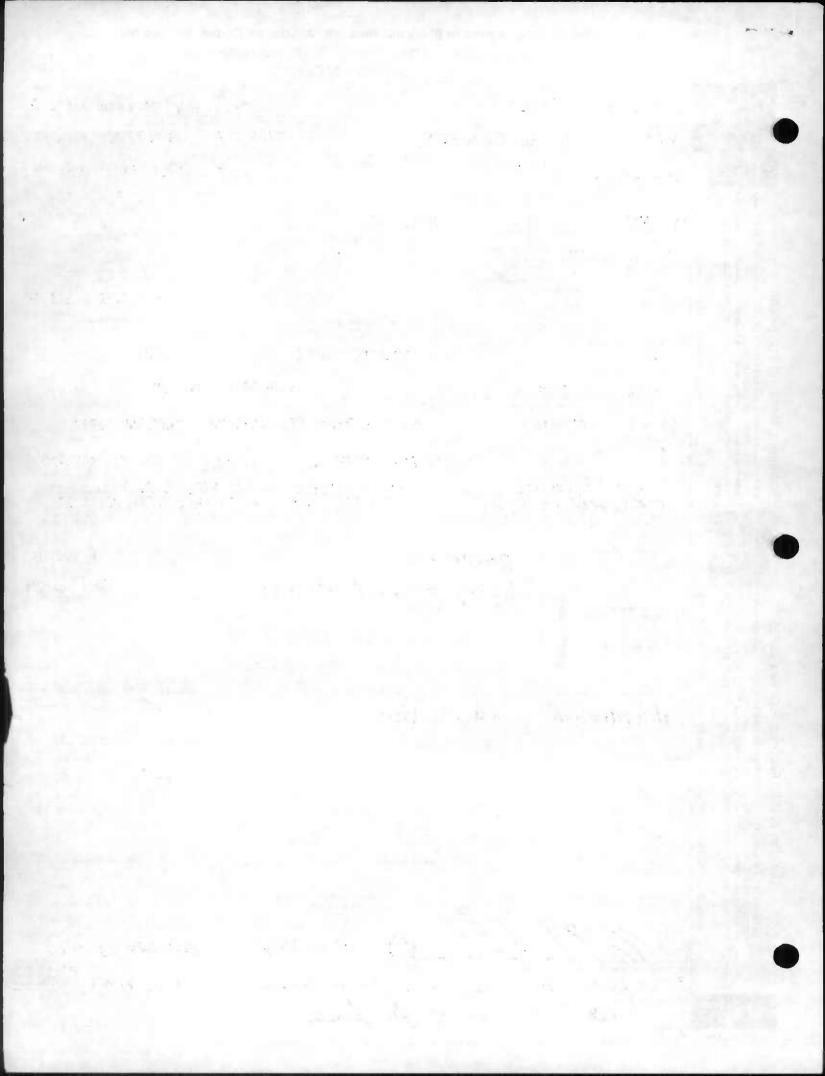
3387 FEBRUARY 23 2000 mon who completed cause of death (Item 23e) (Type, Print)

BALTIMORE DEPARTMENT OF MEDICINE: 301 ST. PAUL PLACE. MD21202

Registrar

edicai

MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 25 2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

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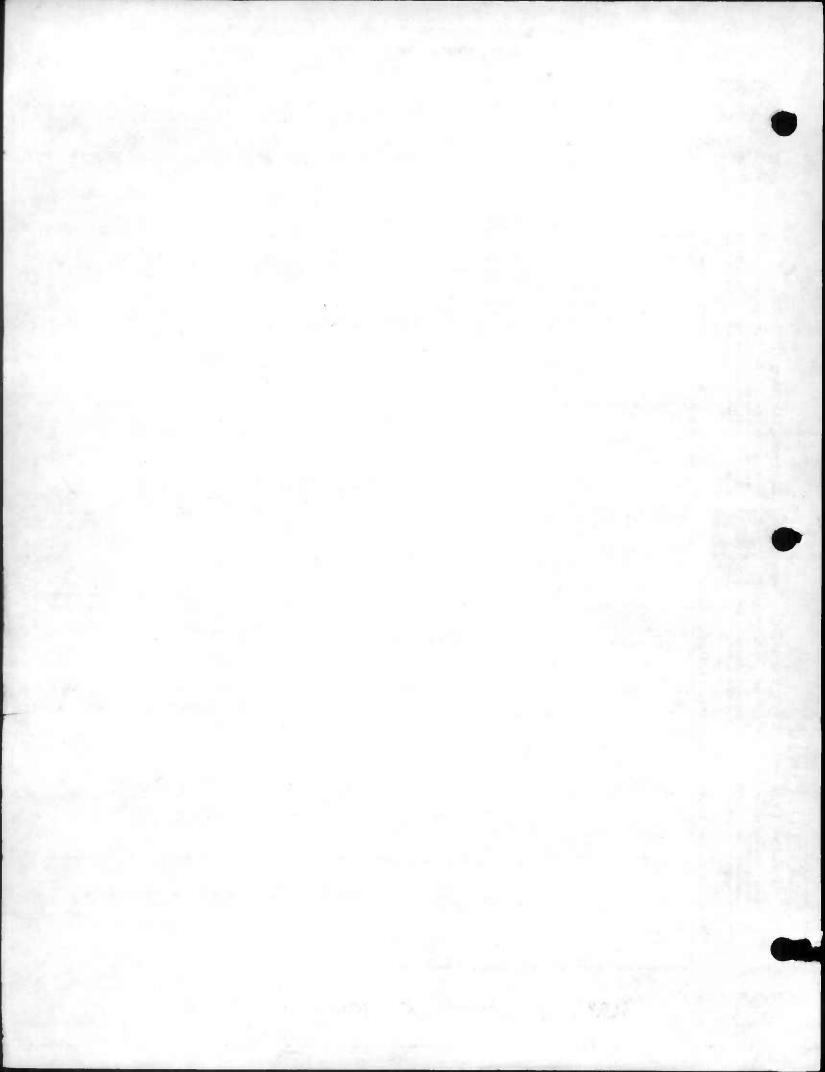
regory ur	tas Jones		Certifica	ate of De	eath	Re	g. No.		0110					
Street along	1. Decedent's Name (First, Middle, La	st)				2. Date of Death		Year	3. Time of Death					
Physician /Medical	GREGORY UR	IAS JONES J	R			Februar		2000	1:10 P.M.					
Examiner	4a Facility Name (If not institution, giv	re street and number)		4b. (	City, Town, or Lo	cation of Death	4c. County	of Death						
	5931 Yorkwood				Baltimo		N	I/A						
Funeral	5. Social Security Number 6. S	KOKM 2DF	Month		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State or Foreign					
Director	213-98-3866 Usual Residence of Decedent	18	Trs.			AUG 20	1981	MAR	YLAND					
Pu & w	10a. State 10b. County	10c. Ci	ty, Town or Location					1	Od. Inside City Limits					
Marylan -f ahow	MARYLAND N/A		BALTI	MODE					1XXYes 2 □ No					
filed within 72 hours effer deeth with the Maryland Hygiena. ther than "natural", or frams 23a or 28a-f show out, the Medical Framt har must be notified as Completed by Funeral Director	10e. Street and Number			Zip Code		10	Og. Citizen of V	Vhat Coun	itry?					
Sa o	2101 WOODBOURN	E AVENUE		21214			U.S.A							
72 hours enter deelh with the Maryle fratural!, or Nama 23a or 28a-f ahov deal Esaminer must be notified at deed by Funeral Director	11. Marital Status	12 Was Decedent Ever in U	,S. 13. Was De		anic Origin? (Spo Mexican, Puerto	ecity Yes or No-	14. Raci	a - Americ						
F. T.	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	100		Specify:	riican, etc.)		k, White,						
"natural", or	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	I L Tes	2 <u>4,1</u> 40 3	эресну:		Specify	BLAC	K					
nt, the Medical Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Decedent's U (Give kind of	sual Occupatio work done duri	on ing most of work	ing	16b. Kind of Bu	siness/Inc	dustry					
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B B	GREGORY U. JONES			18		(First, Middle, M LA A BRA			D					
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office of the state of the stat	Angela A. Salmone  20a. Method of Disposition	20b. F	Place of Disposition (#	Vame of	NE AVENU	JE, BALT	20c. Location -							
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eny Injury or other	21. Signature of Funerat Service Licer		ANEY VALLE	and Address o		2-26-0 dB	ALTIMOR	E, M	AKILAND					
P G	1 Xalend	1/		OMMUNITY FUNERAL HOME PA										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
sician	shock, or heart failure. List only	one cause on each line.							Interval Between Onset and Deeth					
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is the budal-transit edical Examiner	Sequentially list conditions.	b. Due to (c	or as a consequence of	of):				1						
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Physician														
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Completed by Physic						24a. Was ar	ere autopsy findings							
lete						perform		ava	ailable prior to mpletion of cause					
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Be	25. Was case referred to medicat axaminer?	Hospital:	15010 · · · · ·			(Check only one		45	at scene					
tion: To Be Comp	1/ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	DUA	4 LI Nuising no	me 5 Reside 28d. Describe ho			<sub>wat</sub> scene					
Certification:	1 Natural 5 Pending	(Mogth, Day Year)	Found:	28c. Injury at Work? 1 ☐ Yes	s 21 No				d and cut.					
Ifficat	3 Suicide 6 Could not b		ome, farm, street, fact			28f. Location (Str	neet and Numb	er or Rura	Il Route Number.					
100	4 Momicide	28e. Place of Injury - At he building, etc. (Specif Field behin	28f. Location (Street and Number or Rural Route Number, City or Town, State) 5931 Yorkwood Roa Baltimore, Maryland											
To the Hospital or Att within 24 hours after do To the Funeral Direct completely filled in by I Medical Certifit		ysician: To the best of my kno	date and place,	be, and due to the cause(s) and manner as stated.										
edical		niner: On the basis of examina and manner stated.												
×	29b. Signature and title of certifier	THE STREET		29c. License nu			d. Date signed							
	9/1	M. 1/2		O.C.	M.E.	F	ebruary	7 24,	2000					
	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)		01.0									
	Jack M. Titus,	M.D.	111 Pe	enn Str	reet, Ba	ltimore,	Maryla	and 2	1201					
State	31. Date filed (Month, Day, Year) FEB % 5	32. Registrar's Signa	ature	spark	2									
egistrar		3000 Denn												

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dala of Death 3. Tima of Death Day Year Month **Physician** SR. JACILSON EDWARD SAMUEL 23=08 FEB 18 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner GENERAL HOSPITAL HARFORD FALLSTON FALLSTON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 12 M 20 F SEPT 11 1945 Director 54 MARYLAND 217-42-5929 Usual Residence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location t0d. Inside City Limits must be notified at 1 Yes 2XXVo Director MARYLAND HARFORD CO ABINGDON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 3271 MEADOW VALLEY DRIVE U.S.A. Rema : 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Xes 2 □ No If Yes, Give Year or Dates: 6 3 / 7 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after Hyglane. 1 ☐ Never Married 2 X Married 21215-0020 ò 1 Yes 2 No Specify: Specify: py 3 Widowed 4 Divorced BLACK "natural", 63/74 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then. HARFORD CO SHERRIFF Elementary/Secondary (0-12) College (1-4or 5+) DEPUTY 1st CLASS . Pages 1 and 2 should be filed wimant of Health and Mental Hyglan ant: if Nem 27 is marked other th lury or other treumatic avant, the 12yrs OFFICE Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 PEARL JACKSON DAVID S. JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Audrey J. Jackson/Wife 3271 Meadow Valley Dr., Abingdon, Md 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Slata 1 X Hurial 2 Cremation 3 Removal from Stata permit. Page Department of Important: If any Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 2-25-00 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Liceptice 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PAarbara= 321 S. PHILADELPHIA BLVD **ABERDEEN** Approximate Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immedieta Causa (Final ASCUD diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examir Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s The burial Box 68760 Physician/Medical Due to (or as a consequence of) 2 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ž signed by 1 Yes 2 No 3 Probably 4 Unknown HYPERIENSON þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed PCABSG completion of cause of death? 1 Yas 2 No 25. Was case referred to medical axaminar? 26. Place of Deeth (Check only one) Be Hospital: 1 Inpatient 25 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 17 Yes 2 No 27. Manner of Death 10 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, Çity or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide veithin 24 hours of the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DME OCME FEB 18, 2000 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 4 PRABHOMO BELAIR MD 21014 ZIB FULFOND ANG 31. Date filed (Month, Day, Year) F-EB 2 5 2000 32. Registrar's Signature State oaks Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JUCHS FEB 2:20 PM 20 & LEXNOR ,2000 JOSEPHINE /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE 5805 PINEWOOD AVE If Under 1 Year If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Yrs. 91 MD Director 215-16-6384 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 PINE WOOD AVE 21214 U.S.A Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: edical Examin 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry AUTOMOTIVE / RETAIL! Elementary/Secondery (0-12) College (1-4or 5+) MANUFACTURING BOOK KEEPING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be find Mental H SAPPINGTON EUZABETH PUNTE ALBERT M. C. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 GLEN ARM, MD. 21057 Separtment of Health mportant: If New 27 LAWRENCE N. JUCHS, SON OLD CHRRIAGE RD. 11116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition FEB 23 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY PARKVILLE 2000 21. Signature of Funeral Service Licenson 22. Name and Address of Fecility EVANS FUNERAL CHAPEL 8800 HARFORD RD PARKVIUE, MO. 21234 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the diseese, or heart failure. Li Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ATTHEROXCHOTIC CANDIVASCULAR OTSBASS Examiner Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) use as the Box 23b. Did tobacco use contribute to the cause of death? P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown þ Records, 24b. Were autopsy findings evailable prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? page 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 1 Yes 2 No Certification: To 6 ☐Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending Investigation 1 Naturel 2 Accident s after death. 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital Medicai 29a. Certifier 154 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) completely (Check only one) and menner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HIGHLAND AVE HIGHLAND TOWN, MO 21224 F. IBARRA MD. 261 IRENE 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

HW

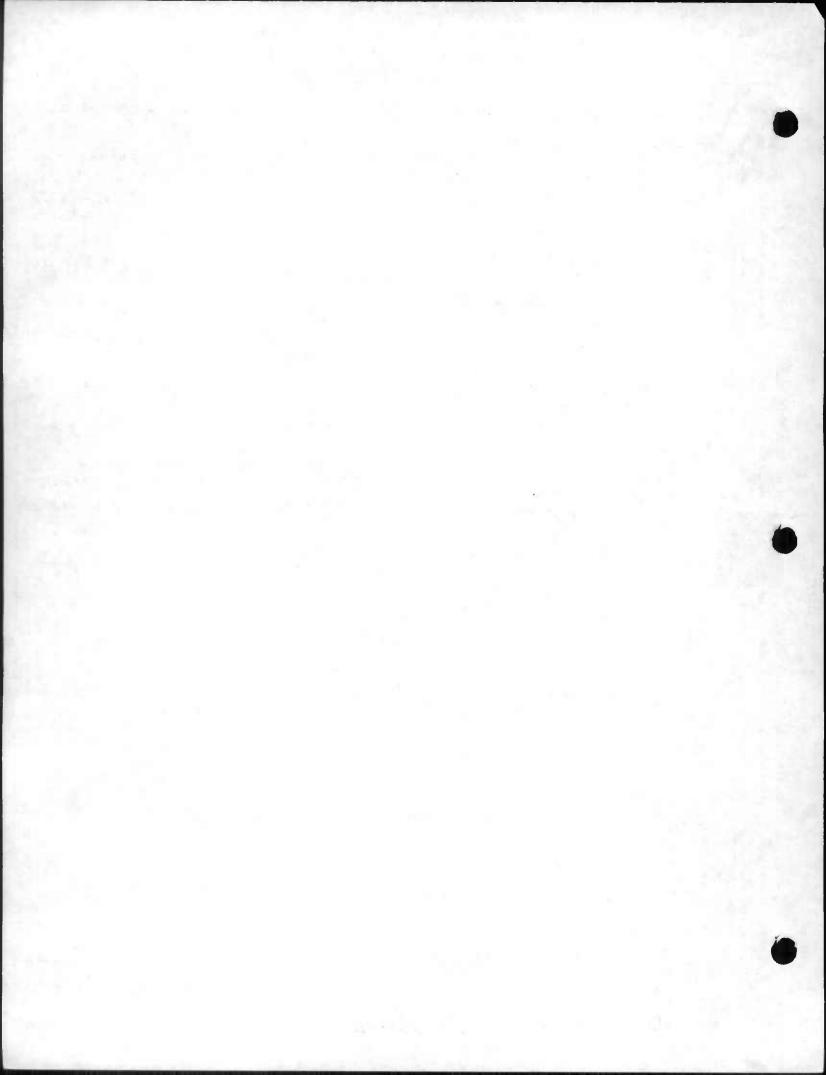
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State of Maryland / Dep

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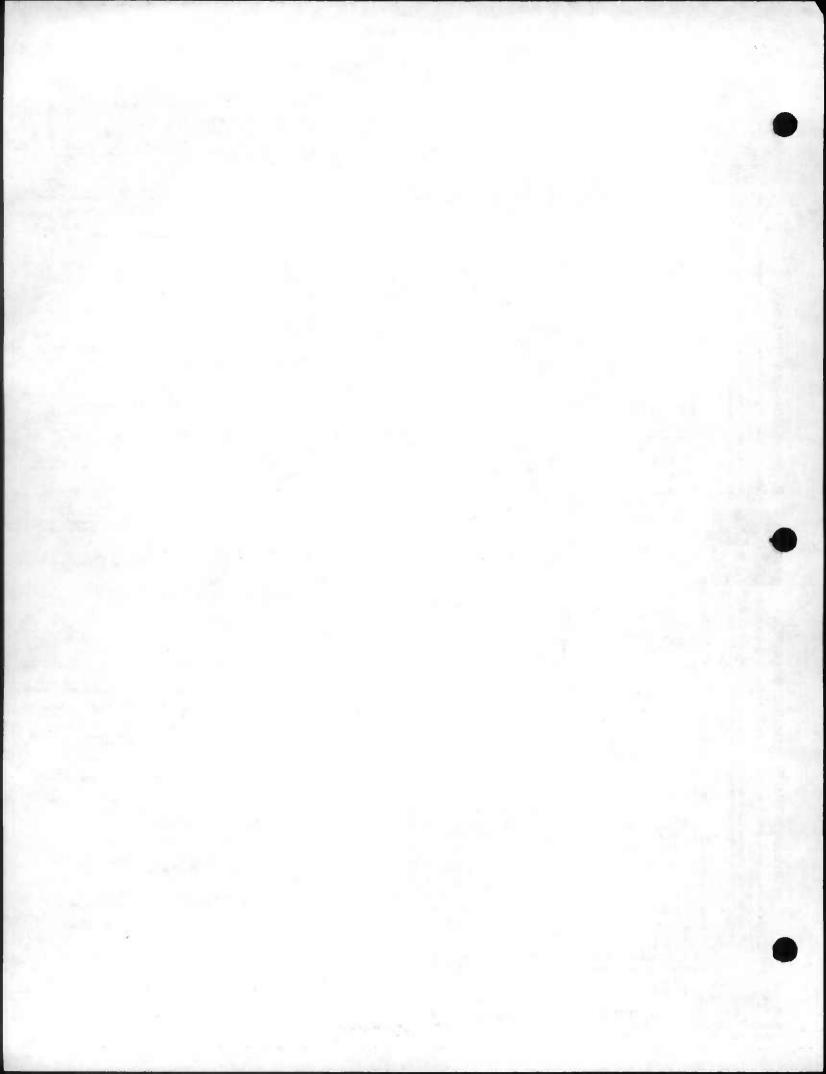
					Ce	ertificate	of De	ath	Re	g. No.					
Physicia	a donum	's Name (First, Midd							2. Date of Deat Month	Dev	Year	3. Time of Death			
Physiciai /Medica	Mary Ann Johnson								FEBRUAF	7:05 A					
Examine	4a Facility 1 1736	E. OLIVE	n, give street and num RST.	ber)				ALT IMOR	cation of Death E	4c. County					
Funeral Director	215-	curity Number	6. Sex 1 M 2 F	7. Age (In yrs. I	last birthday Yrs.	Months I		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, 06-02-	Year) -33	Country	Birthplace (State or Foreig Country) NC			
pue &	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location														
Maryd	MD		NA	Ва	ltim	ore						Inside City Limits  XIXYes 2 □ No			
with the Ma. 3a or 28a-f a	10e. Street a		liver St	reet		10f. Zip C	ode . 213		10	Mhat Country	n				
5-0020 72 hours after death with the Maryland natural, or forms 23a or 28a-f show deal Examiner must be notified at	1 Never Married 2 Merried 1 Yes,			Decedent Ever in U,S. I Forces?  as \$13No Give  13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl  1 Yes 2 No Specify:				lexican, Puerto	lo Rican, etc.) Black, W						
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Ma nd 2 s aith an 27 ia r r traur	Lind								<i>l Route Number,</i> treet F			ID 21213			
orther tra		ol Disposition	<u> </u>	20b. P	lace of Disp	osition (Name	of			20c. Location -					
Page nent o	1 □ Bur 4 □ Dor	rial 24 Chemetion netion 5 Other (5		tate ater	tro	Crematory or other	ory	i	4-2000			le, MD			
Demit. Pag Department Important: any Injury o	21. Signalu	21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue													
	23a. Part1.	Enter the disease, o	complications that ca only one cause on ee	used the deet	Da not er	nter the mode	f dying, si	uch as cardiac o	or respiratory arre	est,	A	pproximate iterval Between			
death certificate be associated estimated by the set of	Sequentially if any, leading cause. Enter that initiated	/ list conditions, ng to immediate er Underlying asse or Injury le events	а. <u>Нур</u> о	Due to (or	as a conse	equence of):	elero	tic Can	diovascu	dar Di	sease				
E 08	resulting in death) Last  Due to (or as a consequenca of):														
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o e en									24a. Was a perform		availe	autopsy findings able prior to bletion of cause			
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Physician: The this certificate ral director, page	examine		Hospital:					. Place of Death	(Check only on	θ)					
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DIVISION ( but or Attending P rs after death. al Director: After ted in by the funer.  Certification:	27. Manner of Death  1											Route Number,			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Mardinel Certification.	29a. Certifie (Check one)		g Phyaician: To the base	est of my know	viedge, dea	th occurred at	he time, d my opinio	late and place, in, deeth occum	and due to the ca	use(s) and ma	anner as state and due to th	ed. ne cause(s)			
To the within 2 To the comple		ure end title of certifie		yll			C.M.		2	ed. Date signe FEBRUA					
State	MAG	d address of person  (Manth, Day, Year)	₩ho completed cause  \$\int_{\inttileftinteta\int_{\int_{\inttileftinteta\int_{\inttileftinteta\int_{\inttileftinteta\int_{\inttileftinteta\int_{\inttileftinleftinteta\int_{\inttileftinteta\int_{\inttileftinleftinteta\int_{\inttileftinlefti	of death (Item	M		enn :	Street,	Baltimo	ore, Ma	ryland	21201			

State Registrar

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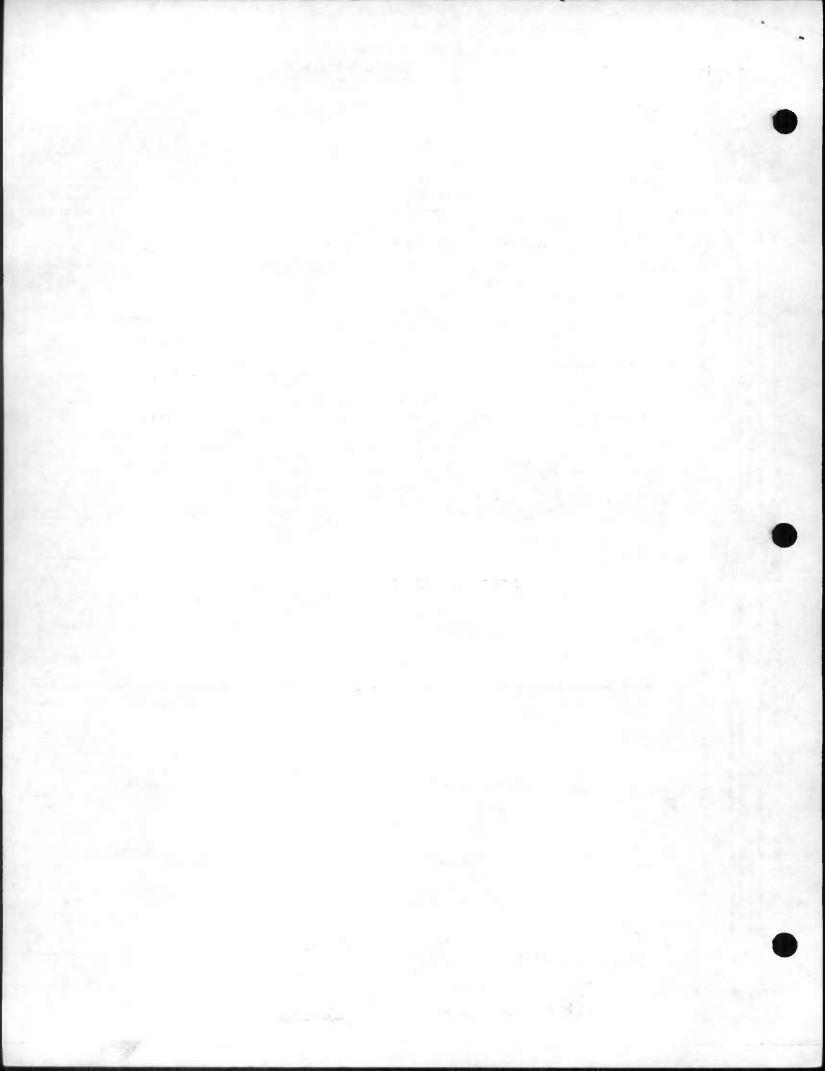
32. Registrer's Signature

Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Amended Item#23a perPHYG780 2/25/2000 EW 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year 5:55 pm **Physician** 4b. City, Town, or Location of Death 18 CECIL, A, JORDAN 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE UNIVERSITY of MARYLAND MEDICAL SYSTEM, 22 S GREENEST, If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4-10-1926 5. Social Security Number 6. Sex 9. Birtholaca (State or Foreign **Funeral** Months Days 10 M 20 F Hours VERGINIA 73 230-34-6516 Director Usual Rasidence of Decedent with the Meryland 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at Y Yas 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 717 DRUID PARKWAY DRIVE APT. 205 21217 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. Neme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status filed within 72 hours effer 1 (☐ Yas 2 ☐ No If Yes, Giva Year or Datas: WW I I 1 Never Married 2 Married 21215-0020 5 Specify: BLACK 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) MACHINIST CATS PAW 7 is marked other treumatic event. aitimore, Marviand 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 is marked off jury or other traumatic even ACEY JORDAN ESTELLA TUCKER JORDAN 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) NANCY DENNIS DAUGHTER 1814 MADISON AVE. BALTIMORE MD 21217 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal/rom State permit. Page Department of Important: If eny Injury or GARRISON FOREST VA CEM. 2-24-2000 OWINGS MILL MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility ESTEP BROS. FUNERAL SERV. P.A. EUGENE 1300 EUTAW PLACE BALTIMORE MD 21217 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Finat RENAL FAILURE disease or condition resulting in death) ACUTE Examiner Dua to (or as a consequence of) Examiner ACUTE TUBULAR NECROSIS Attending Physicien: The lew requires that the death certificate be exacuted the buriel-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): pue Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): . 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2) No 1 Yas 1 TYAS 2 No certificate Division of Vital funeral director, Be 25. Was casa refarred to medicel axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas ZENO 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural To the Hospital or Attending within 24 hours effect death.
To the Funeral Director: Affectoring filled in by the fun 2 ☐ Accident 1 ∏Yas 2 ∏No 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) February 18 2000 40 13363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST-BALTIMORE, M ALANG BRAUN -MARTIN 31. Data filed (Month, Day, Year) FEB 25 32. Registrar's Signatura State DENEUM Registrar



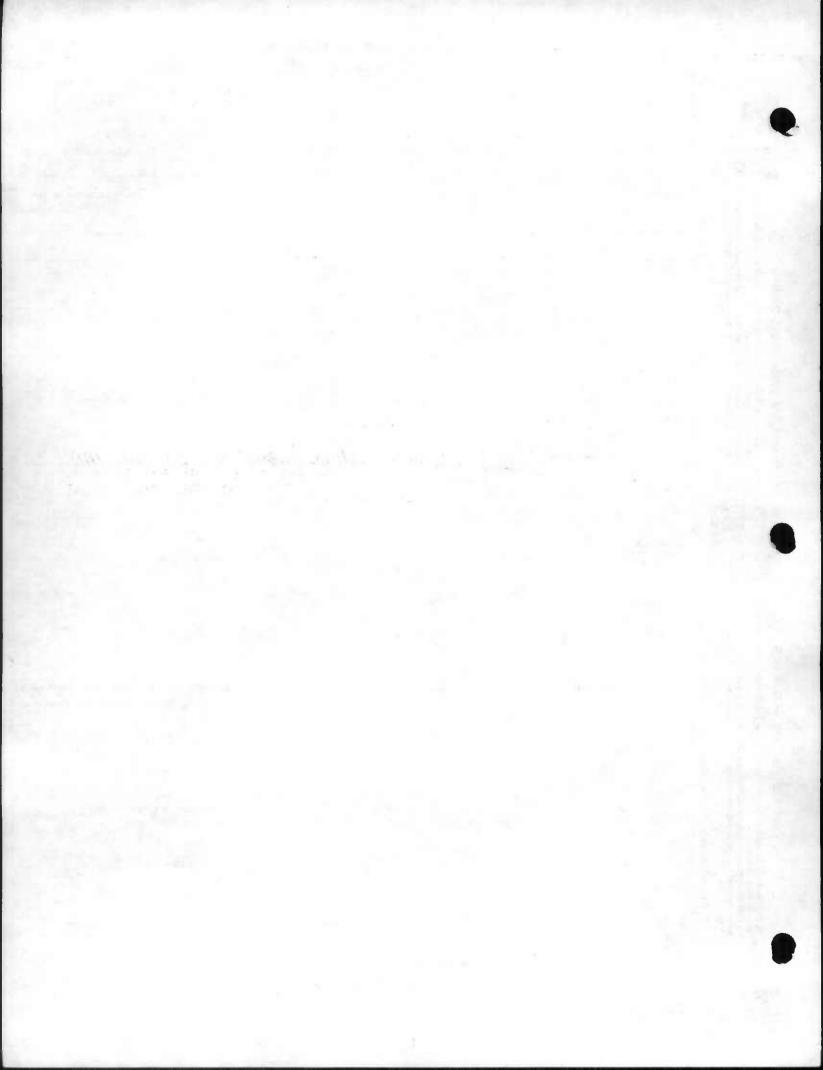
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 20b, 20c, 21, 22, 20a per fh 6780 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** S 0050 Jackson tebruary /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Baltimore Baltimore Center If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2以F 84 220-14-9703 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow na 23a or 28a-f ahor 1)☐ Yes 2 ☐ No Director MD N /A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 611 S. Charles Street 21230 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yaar or Dates: Heme 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Wester Examination. 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: black Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 6 none domestic housekeeping Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Samuel Summerville Estelle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Fred Jackson/son unknown altimore. 20e. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetary, crematory or other place Veteran 1X Burial 2 Gremation 3 Removal from State 4 Donelion 5 Actor (Specify) In State etimore National Compry 2/28/00 Callemne, mi) 21. Signature of Funeral Service Licensee Brendab M, Wyli 22. Name and Address of Fecility Algert R. While Funeral Home Pa 638 N. Gilmor At. Balto., Md 21217 Jaca 23a. Part 1. Enter the disaase or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) Examiner respirator talle The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiete cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last and Due to (or as a consequence of) Box 68760 Physician/Medical the Due to (or as a consequence of): signed by the aid be datached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificata 1 Yes 1 Yes 2 No of Vital Attending Physician: funerel director. 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Satural 5 Pending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. 2 Accident 1 ☐ Yas 2 ☐ No invastigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and manner as stated.
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DHMH 16 Rev 6/95

Registrar

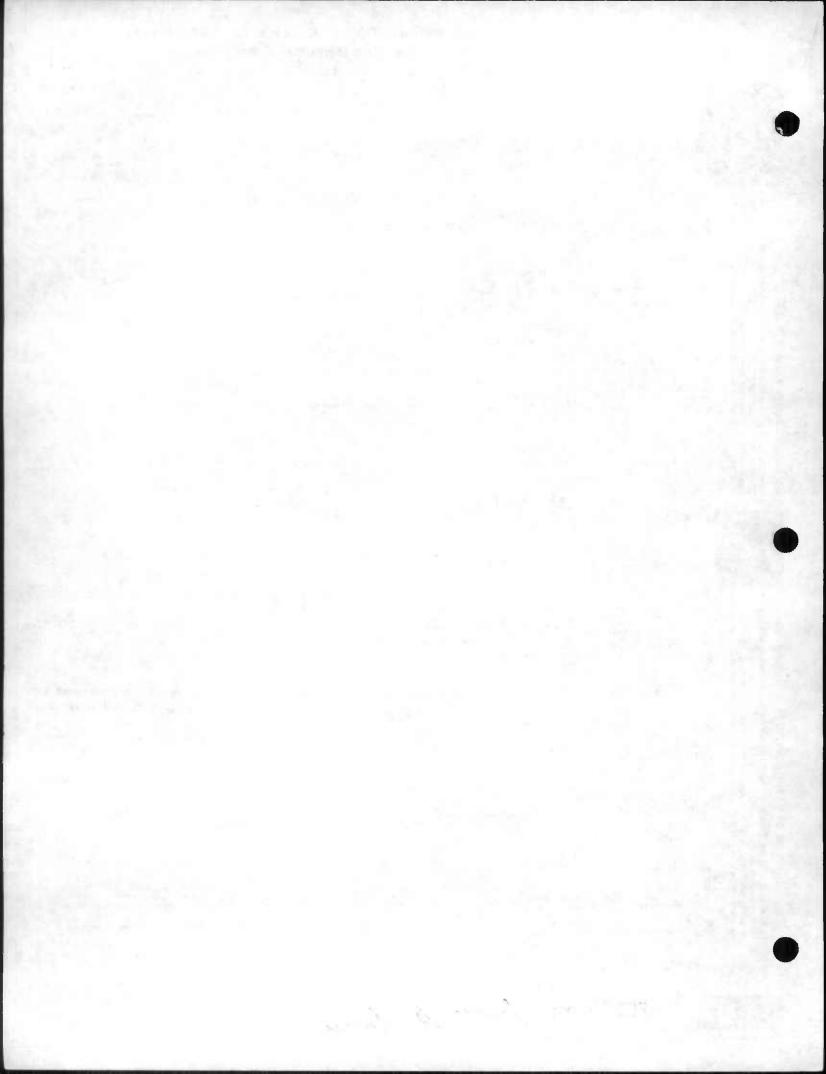
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State of Maryland / Department of Health and Mental Hygiene 0 06121

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1	Physician /Medical Examiner		Immediate Cause ( disease or conditio resulting in deeth)	(Final	а	0	NGES	TWE as a consec	bts	EA	RT	F	AILI	IRE		Two	YEAR	5	
Box 68760,	The law requires that the death certificate be associted at the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician Medical Examination	Ceuse (Disease or injury that initiated events resulting in death) Last  C. The Example of the consequence o										ity YE	R						
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	£ £ #		1 Inpatient 2 EH/Outpetient 3 DOA 4 Nursing H							2	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred								
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	State Registrar		11. Dete filed (Man	3. 2.5° 2(	000	B	wa	B.	Span	Ka									



### Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month RAYMOND R. JOHNSTON 1:45 a.m. February 24, 2000 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 627 S. Atwood Street Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 3, 1943 5. Sociel Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land Months Days Hours 1 1 M 2 □ F 56 217-38-8924 Usuel Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 XYes 2 No Maryland Harford Bel Air 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904-K Martell Court 21014 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Engineering Specialist years Hospital 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Virgil R. Johnston Margaret Smeltzer 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Sharon R. Johnston 904-K Martell Court, Bel Air. MD 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 2/26/00 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21 21. Signeture of Funerel Service Licensee elleer Duan a. U 21014 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear teilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to 24a. Was en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) residence Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 | Yes 2 000 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 DiNetural 5 Pending investigation

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Examiner Physician/Medical þ Completed Certification: To Be

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**Physician** 

/Medical Examiner

altimore, Maryland 21215-0020

of Vital or Attending Physician: Division 24 hours after death. filled in by Hospital Within 2 **\$** 

State

Registrar

Medical

31. Dete filed (Month, Day, Year) FEB 25 2000

2 ☐ Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

29c. License number

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

d address of person o completed cause of death (Item 23a) (Type, Print) mo

6569 N. Charles St Towson 2134

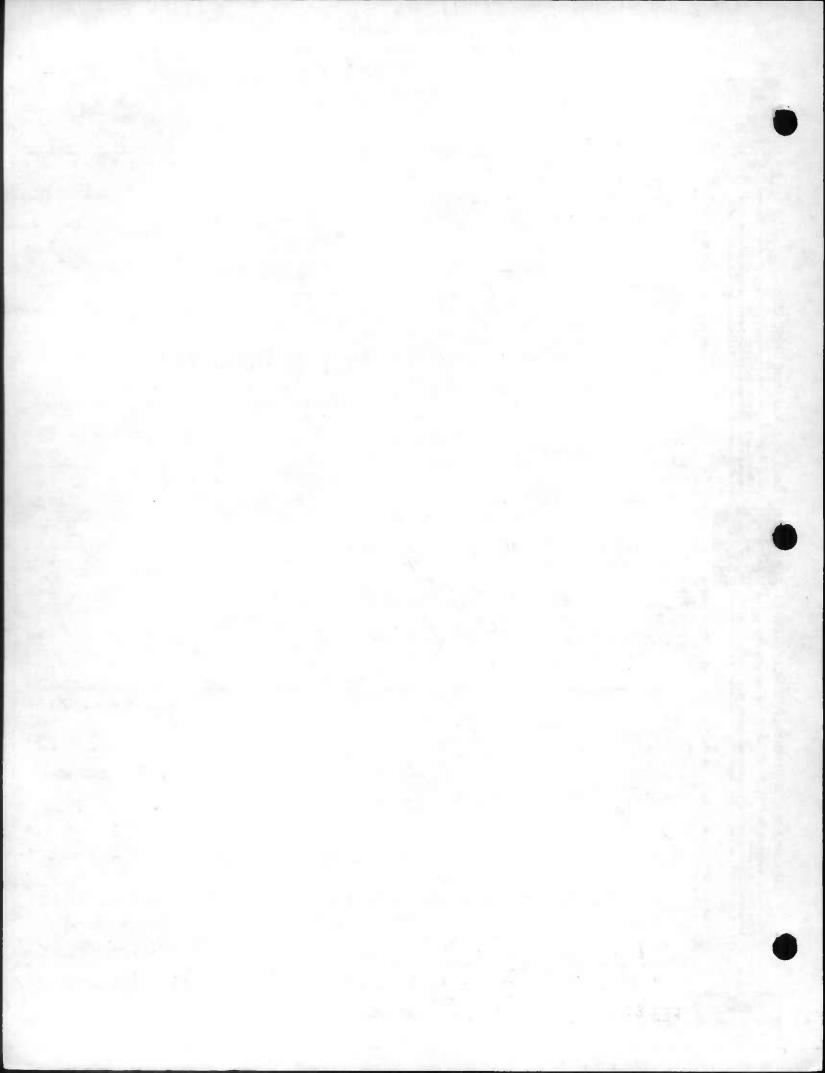
1 Yes 2 No

JO yC 0

6 Could not be determined

32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 23, FEBRUARY 2000 11:40 AM HELEN MARIE JOHNSON /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death **Examiner** MARINER HEALTH OF GLEN BURNIE GLEN BURNIE ANNE ARUNDEL 7. Aga (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Funeral 1□ M 2⊠ F Months Days Hours MAY 28, 1918 WEST VIRGINIA Director 81 216-24-6121 Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show BALTIMORE MARYLAND BALTIMORE CITY 1X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3712 10TH STREET 21225 UNITED STATES Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status be filed within 72 hours after de ntal Hygiene. ed other than "natural", or flam event, the Medical Exemples of 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: WHITE à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event Obta. 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be MYRTLE HALL EDWARD EDMOND EVANS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1100 SOMERSET DRIVE GLEN BURNIE, MD 21061 RAYMOND JOHNSON, JR./SON 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition FEB. Date 25. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata LOUDON PARK CEMETERY 2000 BALTIMORE, MARYLAND 4 □ Conation Statemann (Specify) ENTOMBMENT e of Furlaçal Service Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batweer Onset and Death **Physician** Immediata Ceusa (Final disease or condition rasulting in death) /Medical Dua to (or es a consequence of): Examiner Physician/Medical Examiner ASPIRATION PNOWN ON A physician and s the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last 68760 ADVANCED ALZITEMERS Due to (or as a consequence of) USB 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EHYDRAMON, DECUBITI, CORONAMY Records. by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ARTERY OUGHSE MALWUTERTON t ☐ Yas 2 ☐ No 1 ☐ Yas 2 No Division of Vitai or Attending Physician: 25. Was case referred to medical axaminar? 8 26. Place of Death (Check only ona) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No this 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Certification: 5 Pending invastigation 1 Natural
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To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide tx Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

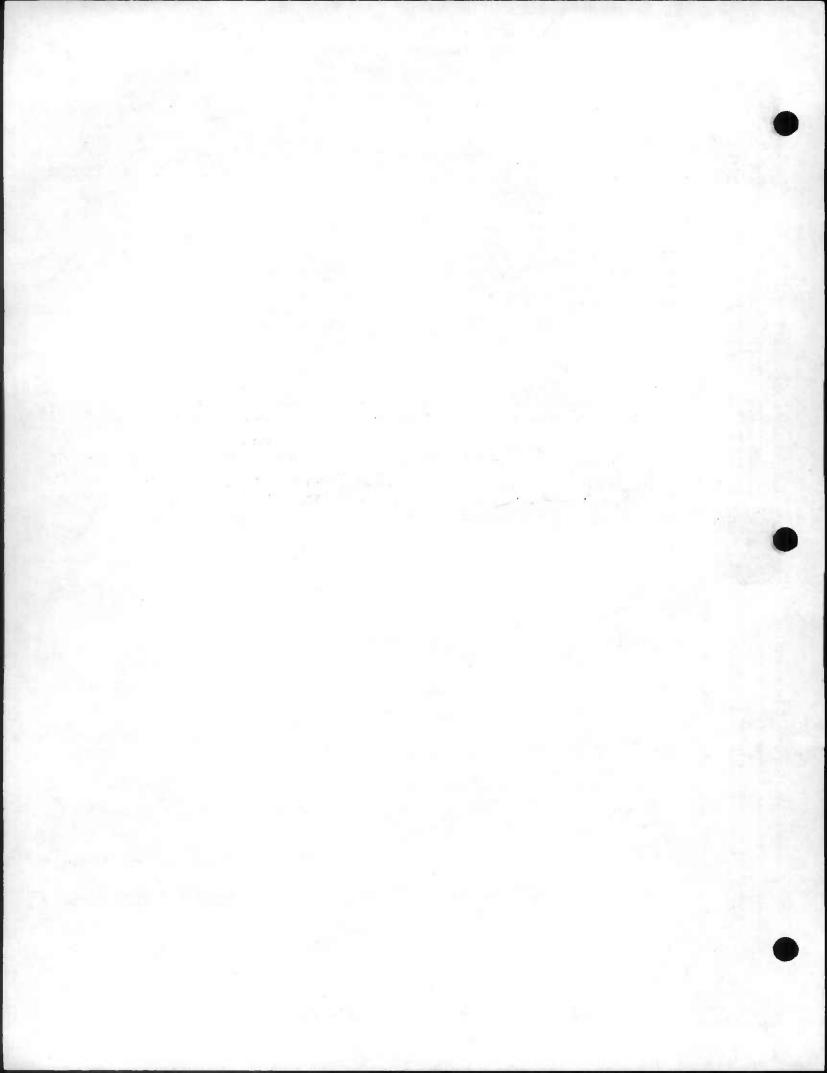
2 Medical Examiner: On the bests of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number menapy MO D52488 FEBRUARY 24, 2000 home Order DD GLENDURONE 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) mo RAMASWAMY I PLANGA PRAJON, 7445A 21060 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State books

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death . Month Yeer 19.35 hrs. ELLIOTT FEBURARY 21 2000 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 900D SAMARITAN HOSPITAL 5601 LOCH KAVENBLYD BALTMORE. 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) DEC 1, 1935 N/A 5. Sociel Security Number 6 Sax Birthplece (State or Foreign Country) 1∭ M 2□ F 216-34-5605 MD Usuel Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2011 JOLLY ROAD 21209 U.S.A. 12. Was DecedenI Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Merital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify 3 ☐ Widowed 4 ☐ Divorced 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BUSINESS MAN - ATTORNEY JOFFE BROS., INC. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL JOFFE IDA 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ILENE JOFFE / WIFE 2011 JOLLY ROAD - BALTIMORE, MD 21209 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Melhod of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donelion \_5 ☐ Other (Specify) 2/24/00 BETH TFILOH CEMETERY WOODLAWN, MD 21. Signeture of 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Entyl the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or need failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finet SEPSIS 4 KIEEKS. diseese or condition resulting in death) Due to (or as e consequence of): RENAL STAGE MONTHS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? END STAGE RENAL DISEASE. 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en eutopsy performed? 24b. Were autopsy findings avelleble prior to ATRIAL FIBRILATION completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es stated. (S) Certaining Physician: 10 the best of his kitchined and place, and the course, and the cour (Check only one)

/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Records, of Vital Attending Physician: Division I or Attendi after deeth Director: A d in by the f To the Hospital on within 24 hours aft To the Funeral Di completely filled in

**Physician** 

/Medical

**Examiner** 

**Funeral** 

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Certification:

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Maryland

Baltimore,

Director

Funeral

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Registrar

MOUHAD 31. Dete filed (Month, Day, Year) FEB 2 5 State

29b. Signature end little of certifier

DAMAJ. 2000

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

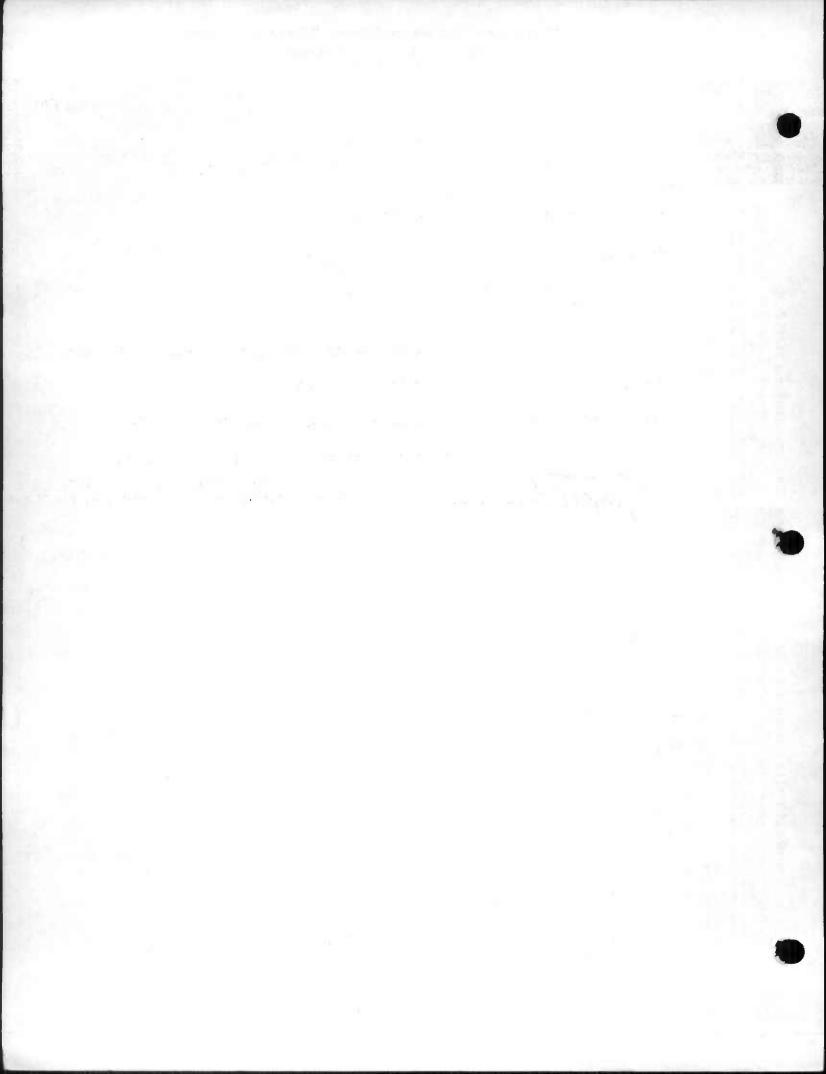
6'00D -32. Registrer's Signature

SAMARITAN

29c. License number

5601 LOCH RAVEN BLUD. BALTMURE

29d. Dale signed (Month, Dey, Yeer)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day FEB 11:30 E. KURZMILLER 22 9000 CHARLOTTE 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) ROAD JOPPATOWN If Under 24 Hrs. 8, Date BALTIMORE 835 CHATFIELD If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 10 M 20 F Months Days Hours Min. Yrs. 220-30-7426 KENTUCKY Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No JOPPA TOWN MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. CHATFIELD RD. 21085 835 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) FLORENCE AMBERT JASON JARRELD 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) JOPPATOWN, MD. 21085 835 CHATFIELD CHARLES L. KURZMILLER, SPURSE 20b. Piace of Disposition (Neme of camatary, crametory or other pieca) Pers 25 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER COM! 2000 BALTIMORE, MD. 22. Name end Address of Facility EVAUS FUNDRAL CHAPEL 21. Signature of Funeral Service Licens ouron 8800 HARFORD RD. PARKVILLE MD. 21234 23a. Part . Enfer the disease, or our respectively. Theart feilure. List of the control of the c ins that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . CONGESTIVE HEAR FAILURE YEARS CARDIOVASCULAR DISEASE ARTERIOSCLEROTIC Due to (or as e consequença of) Due to (or as e consequence of):

**Physician** /Medical Examiner

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The law requires that the

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**Physician** 

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Pages 1 and 2 s ment of Health an ant: If them 27 te :

Maryland 21215-0020

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last

29b. Signeture and title of cartifier

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

1 Yes 2 No

2000

26. Place of Death (Check only ona)

25. Was case referred to medical examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28d. Dascribe how injury occurred

28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Neturai 5 Pending invastigation 1 Yes 2 No 2 Accident 3 Suicide

6 Could not be detarmined 28a. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifiar (Check only one)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

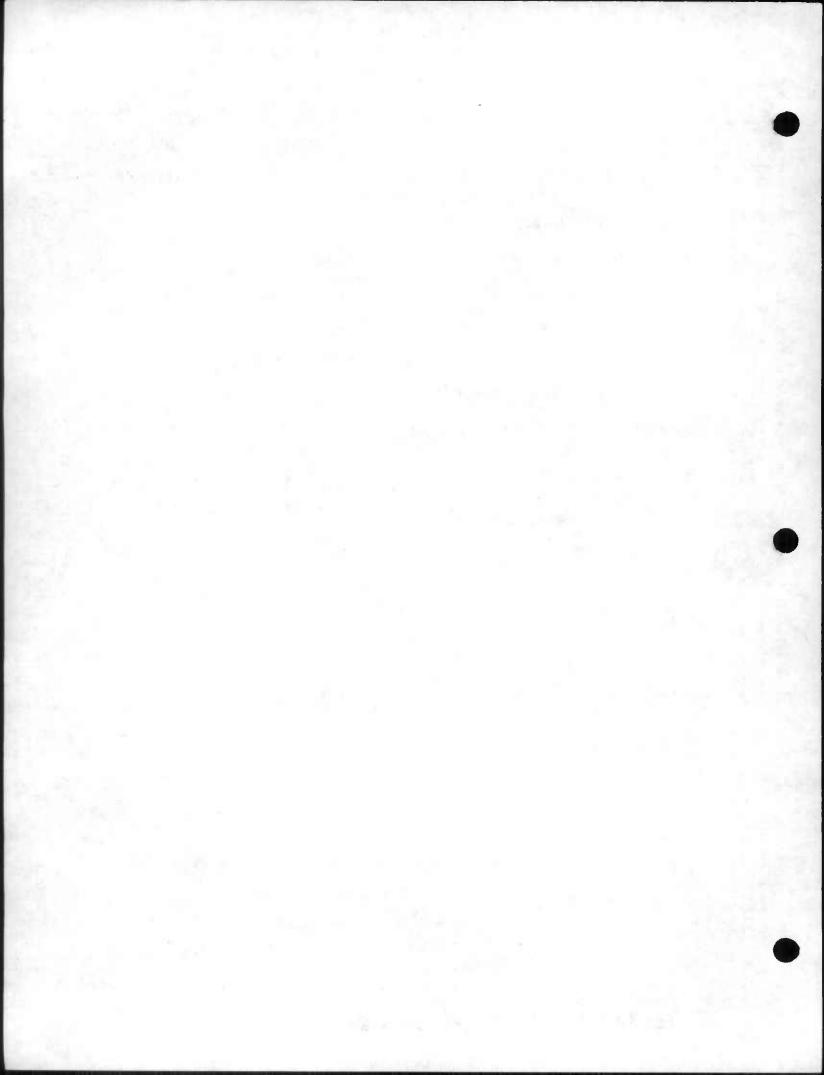
21014 2 NORTH AVE STE. 101 BELAIR, MD.

VIJAY ABHYANKAR MD.

31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

**DHMH 16 Rev 6/95** 

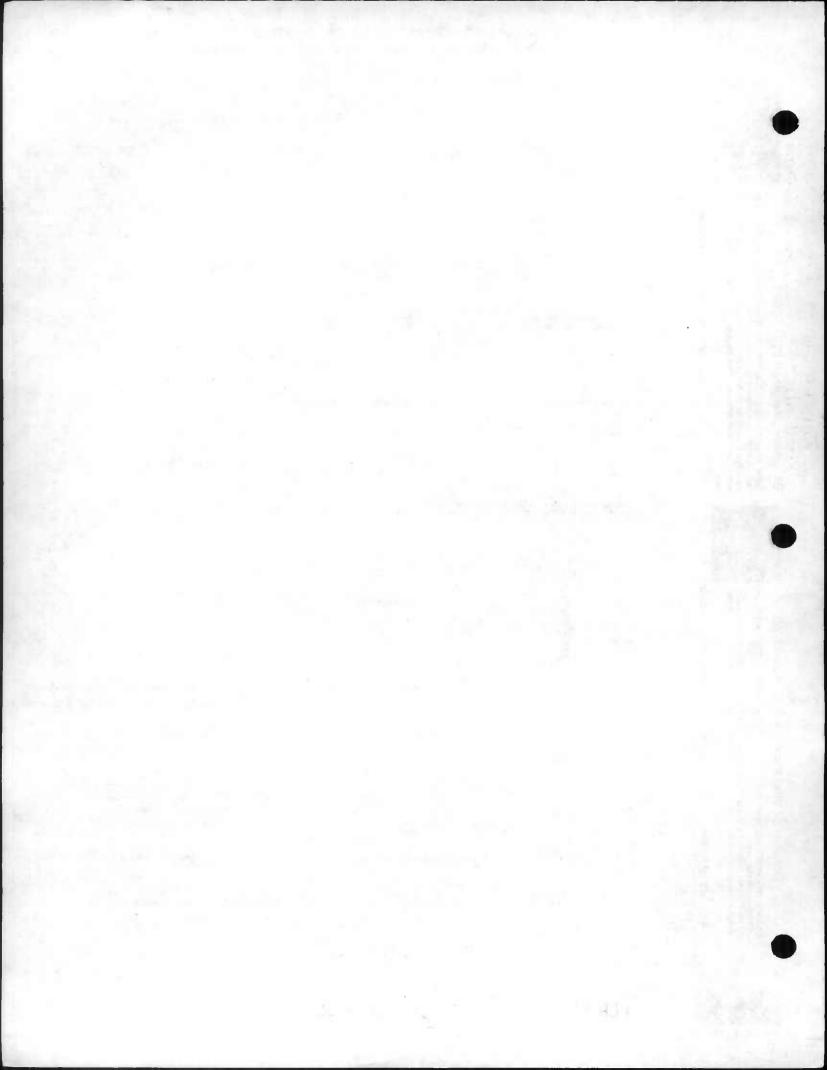
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KNIGH Physician FEBRUARY 2000 TOYCE 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 在五日 Parkville Baltimore Oak Crest Care Center 2/30/00 H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Oct. 18, 1917 5. Social Security Number 9. Birthplece (Stata or Foreign Country) Florida 7. Age (In vrs. last birthday) Funeral 1□M 2V F 265-14-1399 Director Usual Residence of Decedent 90 10a, Stata 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b U.S.A. 8800 Walther Blvd. 21234 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, Whita, atc. 1 ☐ Never Married 2 ☐ Married Specify: White natural, or 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 Mental N тагкад Libbie Woodcock Spencer R Wainright Mae 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Pages 1 and 2 Lewis Knight, Jr. 328 St. Dunstans Road Baltimore, Maryland 21212 #8 altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 2-23-00 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 reman -2 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Life only one cause on each line. Approximate Interval Batween Onsat and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician a the buriel Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecas use contribute to the cause of death? Division of Vital Records, P.O. Haa 2□ No 3 Probably 4 Unknown signed t by 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 10 1 ☐ Yes 2 ☐ No certificata or Attending Physician: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1-ENatural 5 Pending 24 hours after death. 1□ Yes 2□ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Head can be best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

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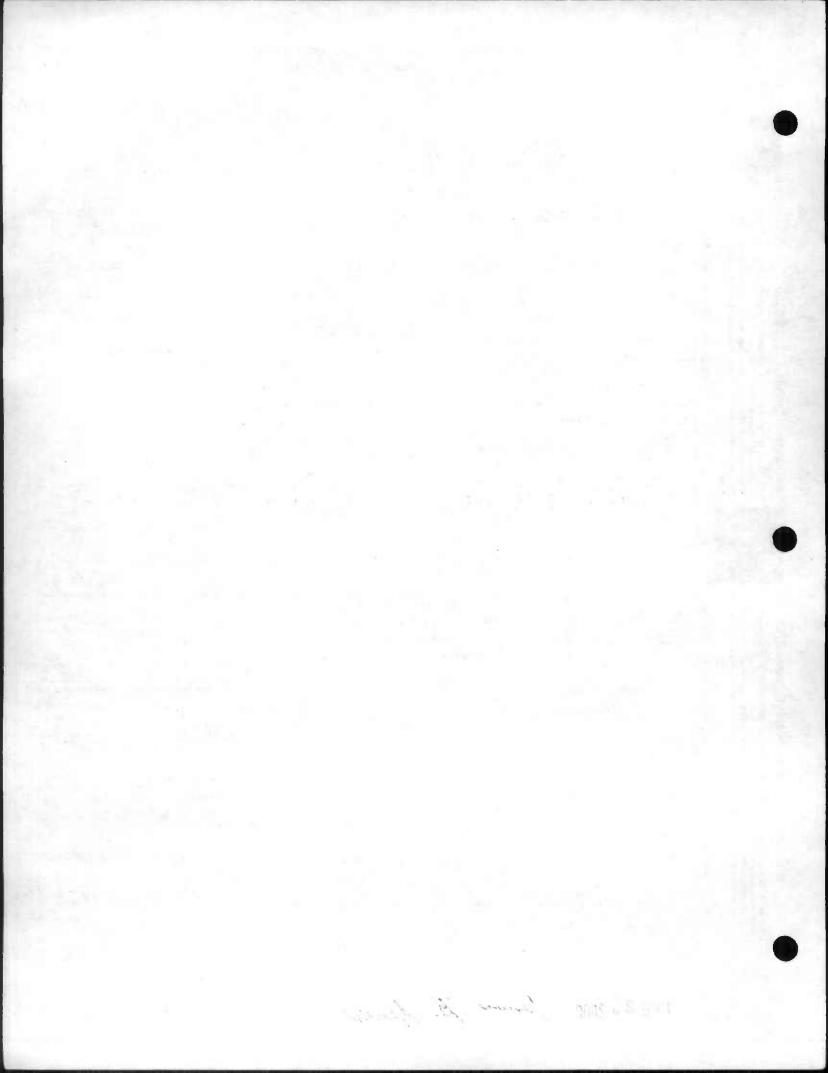
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State of Maryland / Department of Health and Mental Hygiene

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/Medical	Andrew Howard Kreamer, Sr.   Feb gualy 23												1.20 PN
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To Be	James Krea	amer						Bertl	ha				
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to the	1 ☑Natural 5 ( 2 ☐ Accident	Pending investigation	(Mon	th, Day Year)	Injur	М		ork? ]Yes 2∐No					
To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		Could not be determined	28e. Plece buildi	of Injury - At I	home, farm,	street, fect	ory, office		28f. Locat City o	ion (Stree r Town, S	et end Numb Refe)	er or Rural	Route Number,
within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  Medical Certification:	29e. Certifier 12 (Check only 12 one)	Certifying Phy Medical Exami	ner: On the b	asis of examin	nowledge, de nation and/or	ath occurre	ed et the ti	ime, date end p opinion, deeth	plece, and due to occurred at the t	the caus	e(s) end me end plece,	nner as sta and due to t	ted. he cause(s)
within 24 hours To the Funeral completely filled	29b. Signeture and title	of codifice.	and man	ner steted.		1	29c linon	se number		204	Dete signer	1 (Month D	ev Veerl
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000 **Physician** FEB HELEN KRASOWSKI L 21 4:30pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCRIST CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□ M 2⊠ F 219-01-9779 YES 80 Sept. 23 1919 Maryland **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 ☐ Yes 2 No Director 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Poplar Road 21221 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 210 No If Yes, Give 1 Yes 2√ No Specify. Specify: White 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DutchOvenBakery Salesperson 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph Lang Josephine Kreibech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Krasowski / son 9613 Tepid Road Baltimore Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D'Burial 2 Cremation 3 Removal from State St.StanislausCemetery 2/25/2000 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest. Md. 21221 approximate shock, or heart feiture. Light entry one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroschorotie Physician/Medical Examiner End reversaller Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Krasowshi Division of Vital Attanding Physicien: after death Director: A To the Hospital or within 24 hours aft To the Funeral Di completely filled in

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Department of I

**Physician** 

/Medical Examiner

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physician

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After

death.

funeral director,

Pages 1 and 2 should

**Funeral** 

Director

Registrar

31. Date filed (Month, Day, Year) State FFB 2 5 2000

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8565 N. Charles St, Svile 408 NEAL M, TRIEDLAN BER, M.D 32. Registrer's Signature

Fued only, no Mysider

Mendra

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last. 2. Dete of Deeth 3. Time of Deeth **Physician** 3.50 m February Ruby Smallwood Kreusinger 22, 2000 /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa St. Michael Nursing Home Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M XXF Months Days Hours Yrs 93 **Director** 216-09-0328 Dec. 6, 1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23a or 28a-f show the Medical Exampler must be notified at Y Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4800 Seton Drive 21215 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: p 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary **Building Management** 11 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be h and Mental I Harry Elmer Smallwood Annie Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Health and important: If Item 27 is m any injury or other traum pncs. Shirley Gill Niece Pylesville, Maryland 21132 5034 W. Heaps Road Baltimore, 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XOBurial 2 Cremation 3 Removal from State Most Holy Redeemer 2/25/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211

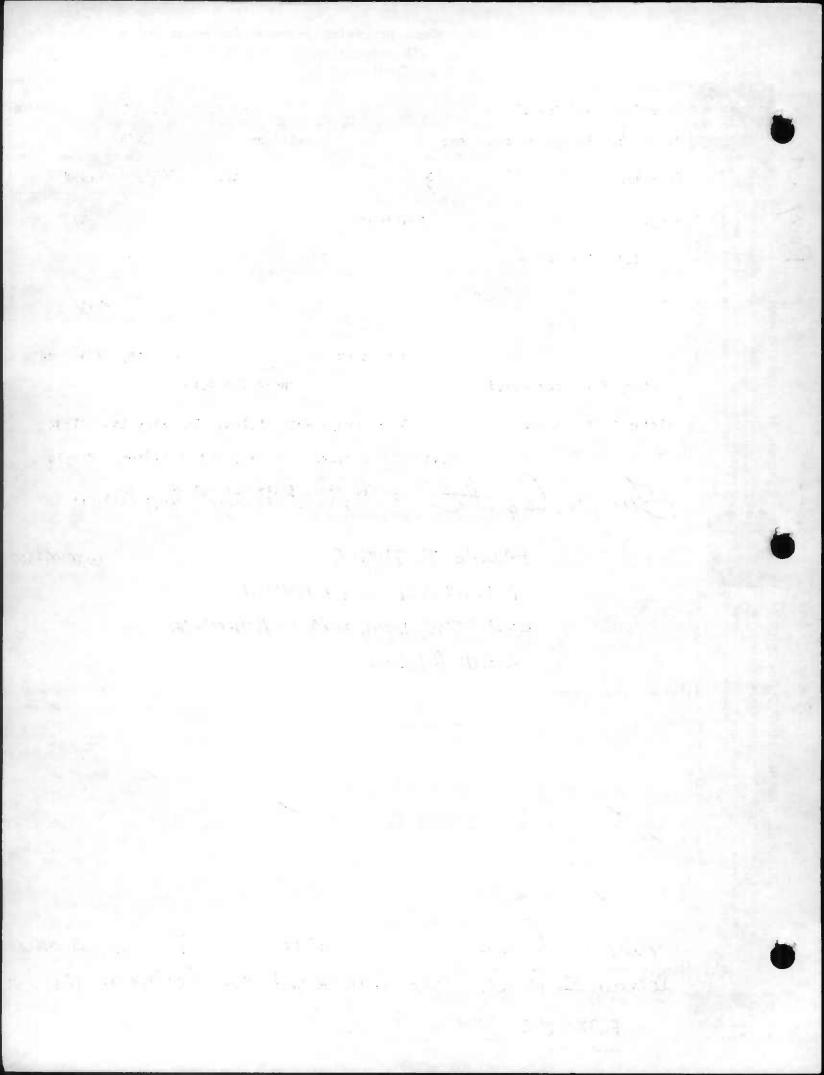
That the please, or complication that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest,

Approximately results only one cause on each line. 22. Name and Address of Facility 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 6 months . FAILURE TO THRIVE disease or condition resulting in death) Examiner DYSPHAGIA 6. OROPHARYNGEAL Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) STAGE DEMENTIA 2° Athorosclerotic
Due to (or es e consequence of): physician the buria Physician/Medical USB as DISGOSE recut signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yss 2 No 3 Probably 4 nknown Division of Vital Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 s 1 ☐ Yes 2 No 1 Yes 2 No director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Attending 1 Natural 5 ☐ Pending aftar death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner as stated. Medical (Check only one) 2 Msdical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. within 2 the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Vellerah & February 23, 8000 H45931 Klerce 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Heights Ave Baltimore MD 7220 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rsv 6/95

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Year BELLE KAPLAN tebruary 11:404 22 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Hours Months 1□ M 2以F Yrs 213-52-7904 88 JAN. 17, MD Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 3010 NORTHBROOK ROAD 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yas, Giva 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) MAX **ADDIS** SARAH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ARLENE GLASER / DAUGHTER 6101 IVYDENE TERRACE - BALTIMORE, MD 21209 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data cematary, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS CEMETERY 2/24/00 WOODLAWN, MD 21. Signature of Funanti rvice License 22. Nama and Addrass ot Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Entar the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart filtura. List only one cause on each line. Approximata Interval Batween Onset and Death Immediate Causa (Final diseasa or condition resulting in death) Schemic Due to (or as a consequence of Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 X No 1 Yas 2 XNo 1 Yas 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier ICortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated.

The law requires that the death certificate be executed Box 68760. Records, P.O. Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalets filled in by the funeral director. vo the Hospital or within 24 hour To the Far

**Physician** 

/Medical

Examiner

Director

Funeral

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29b. Signatura and title of certifier

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31. Data tiled (Month, Day, Year) FEB 2 5

**Funeral** 

Director

pernit. Pages 1 and 2 should be lijed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show early injury or other traumatic event, the Medical Especial profiled and 00.00.

**Physician** 

/Medical

Examiner

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**DHMH 16 Rev 6/95** 

State

Registrar

Sina 32. Registrar'a Signature

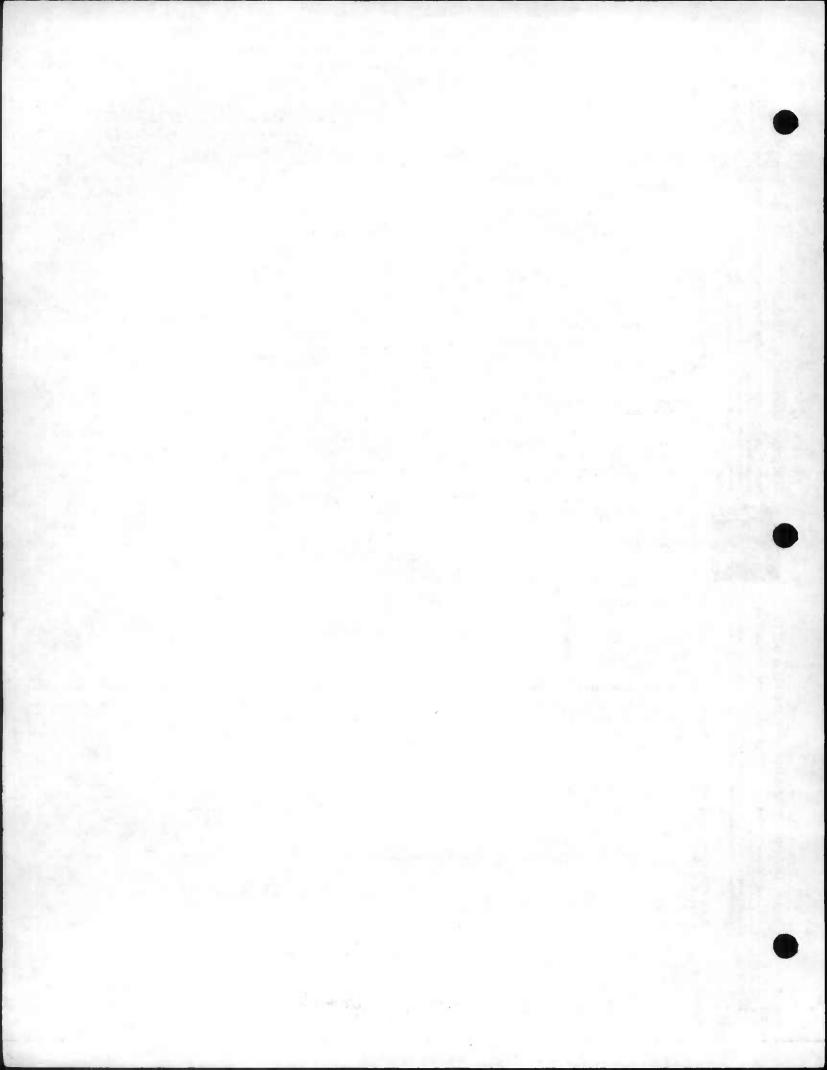
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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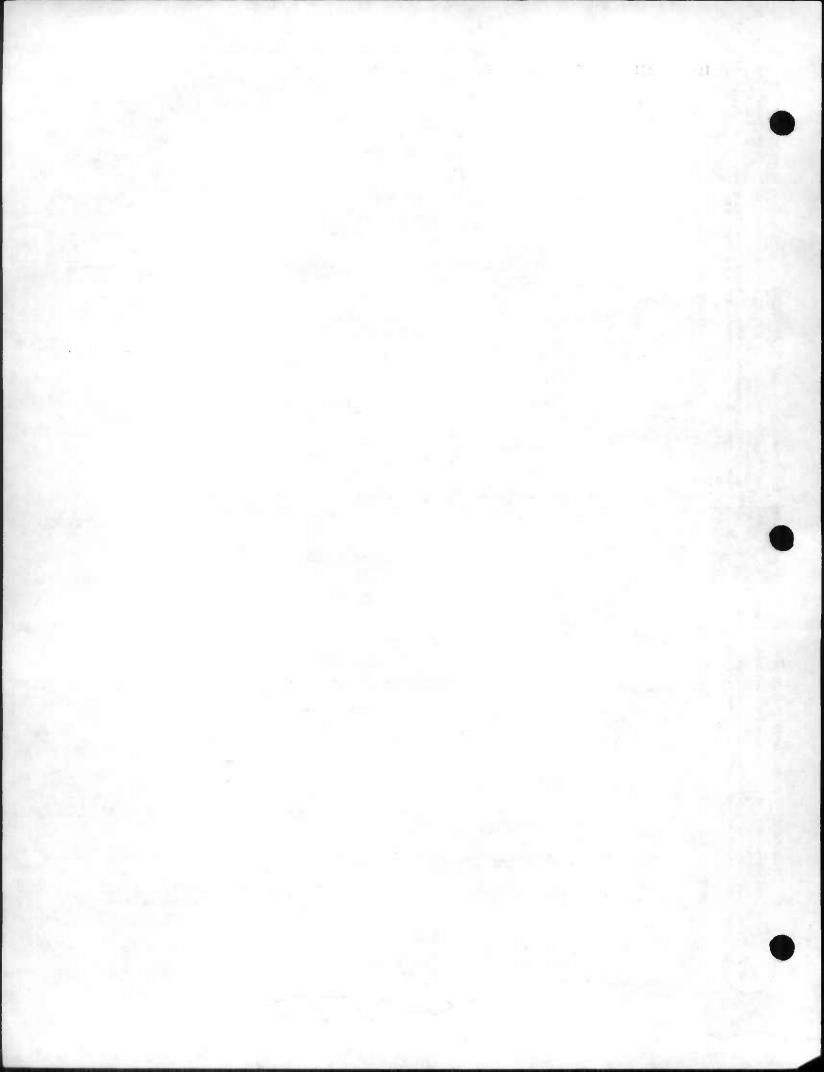
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe

29d. Data signed (Month, Dav. Year)



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24a. Was an autopsy performed?  25a. Was case refarred to medical examiner?  1   Yes   2   No    25b. Was case refarred to medical examiner?  1   Yes   2   No    25c. Was case refarred to medical examiner?  25d. Describe how injury occurred  26d. Describe how injury occurred  27d. Describe how injury occurred  28d. Des	0	the ched	Pert II. Other significant conditions co	ontributing to death but not re	sulting in the un	iderlying cause g	iven In Pert I.	1000000				
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DHMH 16 Rev 6/95



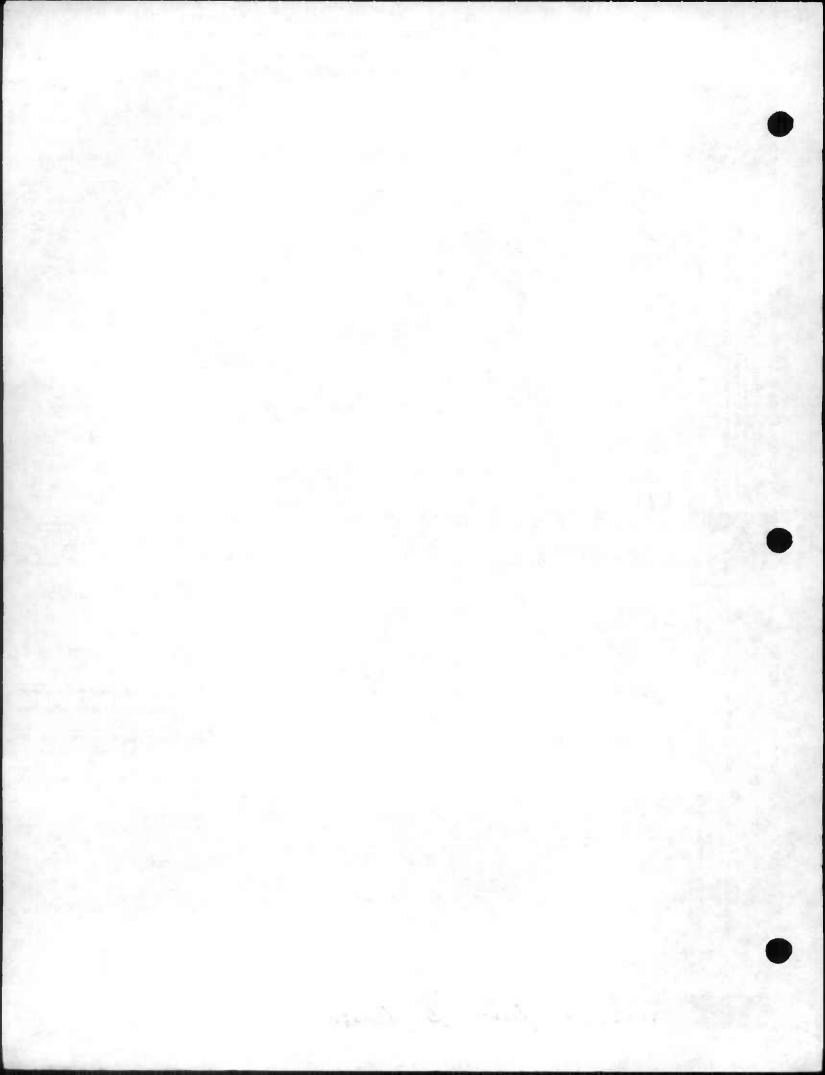
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State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 3 2

Certificate of Death

Reg. No.

						Ce	rtificate	e of	Death			Reg. No	).			
	_	1. Decedent's Nama (First, Middle	, Las	st)										Van	3. Time of Deat	h
Physician		Leslie Royal I	Len	ntz							_				2240	
/Medica Examine		la Facility Neme (If not institution	, give	e street end num	ber)				4b. City, To	wn, or L	ocation of Deat	h 4c	. County	of Death		
LAGITITIC		Anne Arundel M	1ed	lical Ce	nter				Annar	oli	5	A	nne	Arun	del	
Funeral		5. Social Security Number	6. S	ex 7	7. Aga (In yrs. le:	st birthday)			If Under	24 Hrs.						eign
Director		096-28-3539	1	XM 2□F	64	Yrs.	Months	Days	Hours	Min.	June 4	y, Year)	35	New	York	
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Examiner		resulting in death)		a	Dua to for	es e conse	uneuca ot).	UVI	4)18/0	4/	10/ //	4	1/201	131	7	112
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To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the it.	-	29a, Certifier 1 Certifying	a Phy	vsicien: To the h	est of my knowl	edne deet	h occurred	at the ti	ma data ar	d placa	and due to the	ceuse/s	s) and m	annar as s	tated	-
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		oh III	11	mun	111/		1		0/	10		16	-10	0-3	1000	
	1	30 Name end address of person	who o	complated cause	of death (Itam 2	(Type,	Print)	1 ,	1	1	Ar	· N	10.1	5. 1	2000	
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State		31. Data filed (Month, Day, Year)		32. Re	gistrar's Signatu	ra	1	-			/	6	/			
Registrar		FEB 2 5 2000		Janes	10	. 1	ook	21								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Langtry E. February 22 4:50 P.M. 2000 /Medical 4a Facility Name (If not Institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Rosedale
If Under 24 Hrs. 8. Date of Birth
Hours Min. Feb. 8, 1919 FRANKIIN SQUARE HOSPILAL Center | BAITIMORE 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 100 M 2□ F 141-24-5024 81 Canada Director Usuel Residence of Dacedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd., Apt. #2001 21234 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried natural, or 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Geologist Chemical Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health end Mental Estella Lewis Emmett Annie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Violet M. Lund 8800 Walther Blud., Apt. 2001, Parkville, MD 21234 Important: If itam 27 any Injury or other tr (wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Department of 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/24/00 Green Mount Crematory Baltimore. Maryland 21. Signeture of Funeral Sarvice Licenses 22. Name and Address of Facility Buran Schimunek Funeral Home. Inc. elleu 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** Immediate Ceusa (Final disease or condition resulting in deeth) /Medical · Sepsis Examiner Due to (or es a consequence of): Physician/Medical Examiner Preumonis ASDIRALION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): The lew requires that the death certificate be assect P.O. Box 68760. CEREBROUASCHIAR Acciden Due to (or es a consequence of): Pert fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown FibRILLATION, Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Wes cese referred to medical axaminer?

1 Yes 25 No Hospitel: 1 Unpatient 2 ER/Outpet 2 N No 1 Yes 1 ☐ Yes 2 ☐ No of Vitai or Attending Physicien: 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 Meturel 5 Pending s after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of fnjury - At home, farm, street, fectory, office bullding, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Dicompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of ceptifier

State Registrar

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

9000 FRANKlin

Registrar's Signature

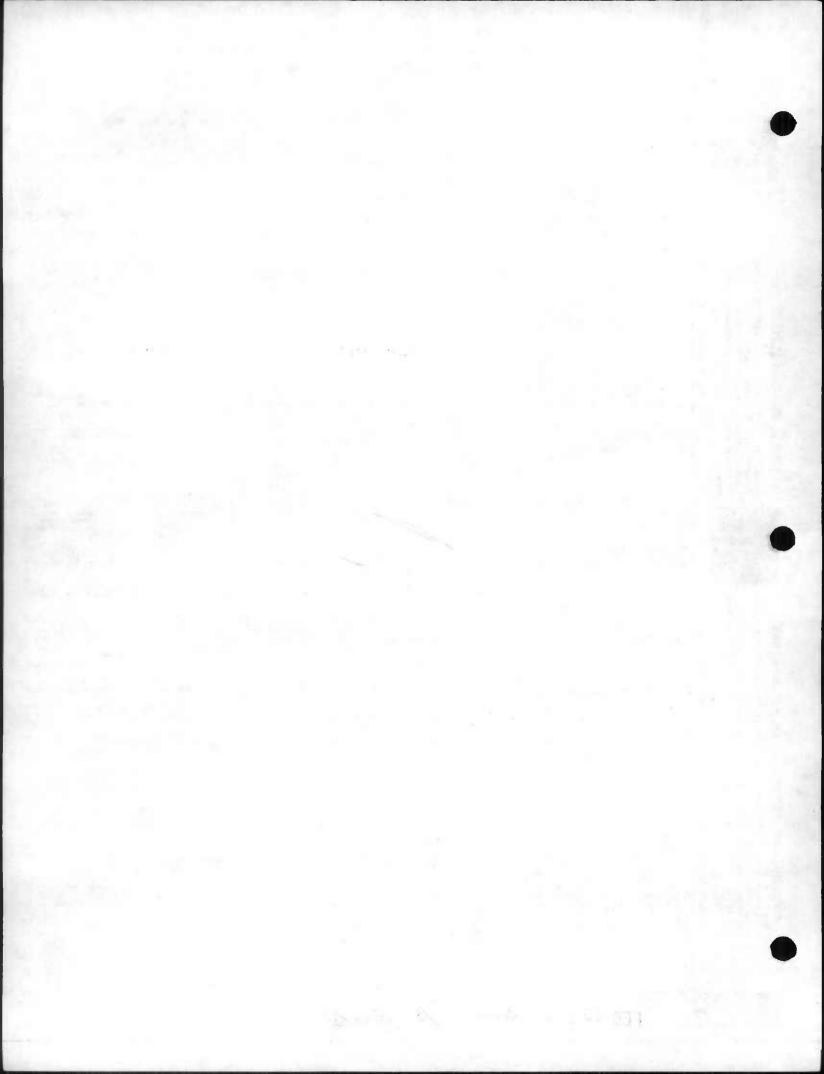
SQUAREDR. BAITIMORE, MARYLAND 21237

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KAYLA GIRON-BAKER

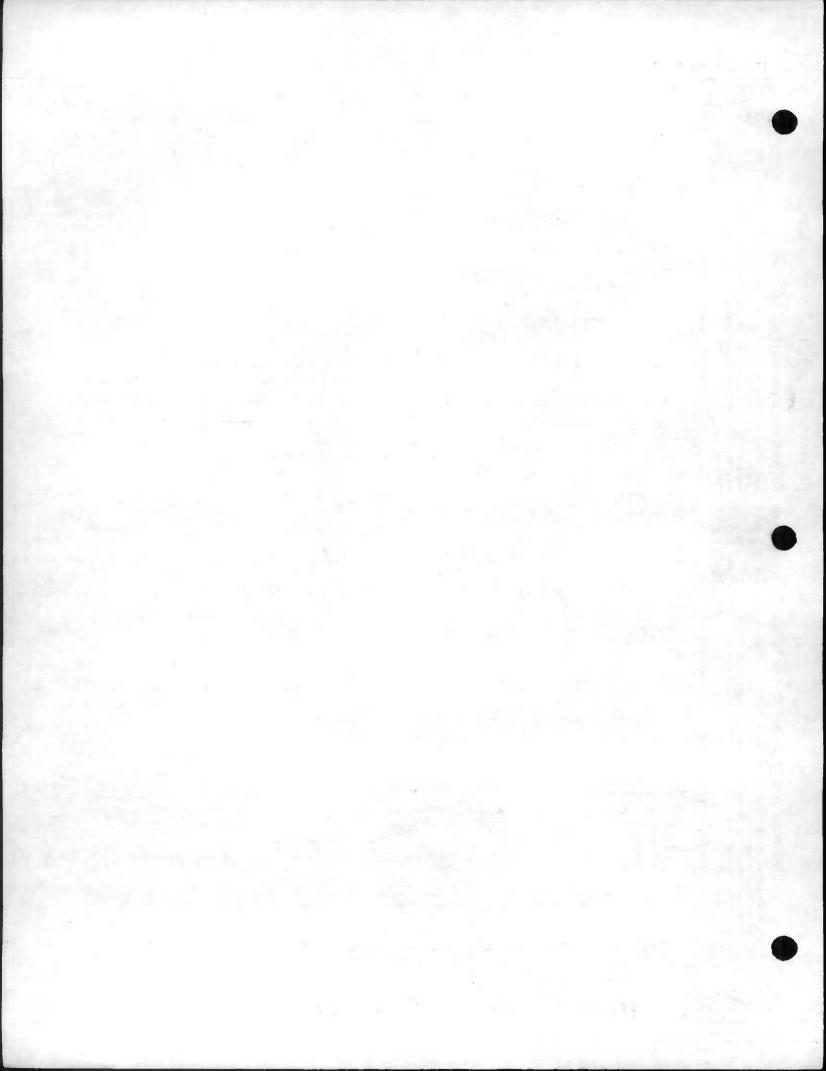
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31. Dete filed (Month, Day, Year)



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AMEN	DED ITEM 196	PER	FH G780 2/25/2000 AH  1. Decedent's Name (First, Middle, L	act)		Certificate of	Death	2. Date of De	Reg. No.	3. Time of Death			
	Physi	cian	JULIA	=51)	т.	LITWIN	T	Month	Day	Year Fr 211 DA1			
-	/Med		4a Facility Name (If not institution, g	ive street and number)	Т.	TIIMIN	4b. City, Town, or L	rebruce ocation of Death	4c. County	400			
	Exam	iiner		A.	BAlti	MORE	BALTI			N/A			
	Funera	1			a (In yrs. last bin	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, De	th .	Birthplace (State or Foreign Country)			
(	Directo	_	140-28-6989	1□M 2\\ F	86	Yrs. Months Days	Hours Min.	JUNE 1	, 1913	N.J.			
itwin	Du k		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits			
7	ith the Maryler or 28a-f show	tor	MD BALTI			1 ☐ Yes 2√2 No							
Ī	h 15	Director	10e. Street and Number		10g. Citizen of V	What Country?							
	th wit		6803 DARWOOD DR:	IVE		21209		U.S.	Α.				
		Funeral	11. Marital Status	12. Wes Decedent E Armed Forces?		13. Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yas or No Rican, etc.)	- 14. Rac Blac	e - American Indien, ck, White, etc.			
	020 Jura ette	by	1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2💢 No			Specify				
8	5-0 72 ho	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	16a.	Decedent's Usuel Occu (Give kind of work done	during most of work	cing	16b. Kind of Br	usiness/Industry			
当	121 Within	mpl	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire	ed)						
B	200		17. Father's Name (First, Middle, Las	<u>(</u>	DE	NTAL HYGIEN	18. Mother's Nem	e (First Middle	DENTAL Maiden Sumen	ne)			
	d be ented	o Be	HERMAN	-		TARGAN	CLARA	o (i wai, imadio,		UNKNOWN)			
8	Should Maria	H	19e. Informant's Name/Relationship	(Type, Print)	19b.	. Mailing Address (Stree	t and Number or Rui	rai Route Numb	er, City or Town,	State, Zip Code)			
5			ROBERT LITWIN	/ SON		90 W. NORTH				RE, MD 21210			
3	OT G		20a. Method of Disposition		20b. Plece of cemeter	Disposition (Neme of y, cremetory or other ple	ace)	Date	20c. Location -	City or Town, Stete			
Pegenting Page		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		CHIZU	K AMUNO (AR	RLINGTON)	2/22/00	BALT	IMORE, MD				
太	Balt.		21. Signature of Funeral Service Lice	enseé/		22. Name end Addre	ess of Facility	SOL LEV	INSON &	BROS., INC.			
(	W 40200		8900 REISTERSTOWN ROAD - PIKESVILLE, MD 212										
		V.	23a. Part f. Enter the disease, or cor shock or heart failure. List on	polications that caused y one cause on each lin	the death. Do r	not enter the mode of dy	ing, such es cardiec	or respiretory e	rrest,	Approximate Intervel Between Onset and Death			
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	Examine	r	disease or condition resulting in death)	. Iscr	Dun to for as a	bowe of consequence of):	/			1			
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	oute oute	Examiner	U. — III — I										
	50, sees	ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	876 Dete to	dical	that initieted events resulting in death) Last		Due to (or as a c	consequence of):							
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	T the debt	by Pi	Coronary a	Coronary artery disease						2 No 3 Probably 4 Unknown			
	quires	po p						24a. Wes	en eutopsy omed?	24b. Were autopsy tindings available prior to			
	w v re	Completed						perio	mileur	completion of cause of death?			
		Com						10	Yes 2 No	1 ☐ Yes 2 € No			
	/ita	8	25. Wes case referred to medical axaminer?				26. Place of Dea	th (Check only o	one)				
	hysic of this o	2	1 Yes 2 No	Hospital:		tpatient 3LI DOA			dence 6 Oth				
	Bing F	lon	27. Manner of Death  1 Netural 5 Pending	28a. Date of Injury (Month, Day	Year) 280. I		ork? □Ves 2□No	280. Describe	how injury occur	red			
Records, P.O. Box 68760,   The law requires that the death certificate be executed by the eitending physician and   Baltimore, Maryland 21215-0020	ision then death stor:	Icat	2 Accident investigation   M   1   Yes 2   No   3   Suicide   6   Could not be determined determined   28e. Plece of Injury. At home, farm, street, factory, office   28f. Location (Street end Number or Rural Route Number,										
	DIV A Pire	- Tre	4 Homicide determined	building, etc.	. (Specify)	m, stroot, tastery, smoo	X - A	City or To	wn, Stete)				
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	ithin S of the	Med	29b. Signature and title of certifier	and menner stel	ted.	29c. Licen	se number		29d. Date signe	d (Month, Day, Year)			
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			7 / / 000000000000000000000000000000000	0.20	, -1	1	)	1	Company of the company	1 - 1			
		21	30. Name and address of nerson who	completed cause of de	aath (Item 23a) (	Type Print)				1			
	0		30. Name and address of person who will be a second of the	ber DO	sath (Item 23a) (	Type, Print)  nai 1+2	ospita	1					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** UNNEILA 2000 23:200 FEB /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F MARJIAND SON Yrs. Director 10b County 10c. City, Town or Location 10d. Inside City Limits Baltmore 1 Yes 20 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours effer deeth with 1 Department of Heelth and Mentel Hygiene. Important: If fem 27 is marked other than "natural", or frame 23a or 2 any injury or other treumatic event, the Medical Experiment 2005. 21228 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Specify: White 1□ Yes 21 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Typg; Print) 20b. Place of Disposition (Name of cemetery, crematory or other p Hilton are MD 21778 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) aurel. 22. Name end Address of Fecility WITZKE FUTCH HOMES, INC LISO EMONDSON 3V5 CATO Do not enter the mode of dying, such as cardiac or respiratory arrest, 21. Signature of Funeral Service Licenses CATORGUILE, MA Approximete Intervel Between Onset and Death Physician MYOCARDIAL 9 DAYS /Medical Immediata Cause (Final disease or condition resulting in death) INFARCTION Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Naturat 2 Accident 5 Pending investigation 1 Yes 2 No

LEIMBACH IAME ANNELLA

Baltimore, Maryland 21215-0020

To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b.

State Registrar

6 Could not be

NASSERI

horse As 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifie

Messu

**DHMH 16 Rev 6/95** 

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BALTIMORE

28e. Place of tnjury - At homa, larm, street, factory, office building, etc. (Specify)

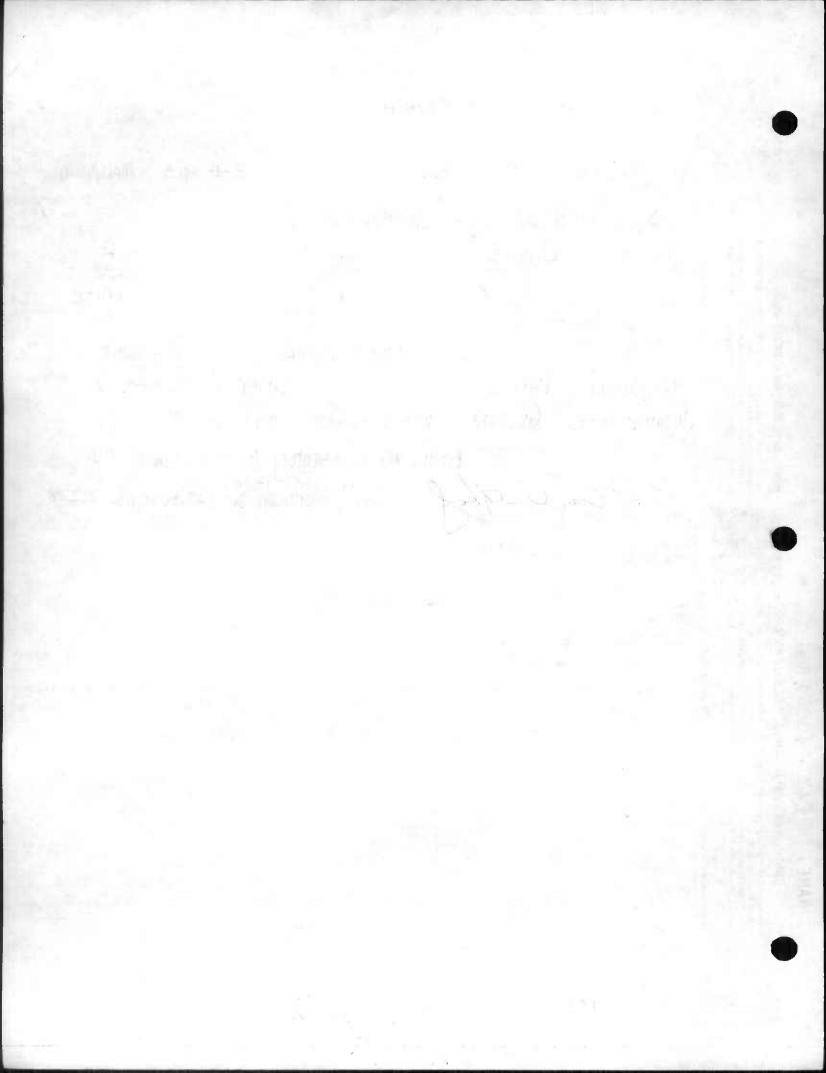
ALL MID. 800 CATON AVE

20 Registrar Signature

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

MARYLAND

29d. Date signed (Month, Day, Year) FEB, 22, 2000



amend item 23a,b,c, per md G782 4/10/00 yg Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item 10f per fh g781 3/3/2000 ah Amended Item#25 perPHYg780 2/25/2000 EW Certificate of Death 2. Date of Death Month 2800 **Physician** 705 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthdey) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□.E Hours Months 75 370-30-6377 **Director** 05 08 1924 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director Anne Arundel Annapolis 'natural', or flams 23s or 28s-f must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 900 Van Buren Street 21043 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Merrled Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: þ 3 Widowed 4 □ Divorced white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Hairdresser Salon 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H is marked of 2 Jessie Reese John Ross 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
The department of Health as important: If them 27 is a siny injury or Judy Henneke/daughter 303 Likes Road, Edgewater, Md. 21037 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ €remetion 3 ☐ Removel from Stete 01-07 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Valley Crematory Bay City, MI 21. Signeture of Funerel Service 22. Name end Address of Fecility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. Listonly one cause on each line.

DISTINCTION ACCUMENT ASSETS ACCUMENT A Approximete Intervel Between Onset end Deeth **Physician** MONIA 12hrs /Medical Immediate Causa (Final diseese or condition resulting in deeth) Examiner CEREBRAL VASCULAR ACCIDENT 6wks 6 be executed ettending physician and for use es the burial-tran Sequentielly list conditions, if any, leeding to immediate cause. Enler Underlying Ceuse (Diseese or injury that initieted events resulting In death) Last ATRIAL FIBRILLATION vears Due to (or es a copsequence of): Box 68760 Physician/Medical Due (or es e consequ P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? cate has 2 DNO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of

After i or Attending after death. Director: After

:ector:

n 24 hours and Funeral Distely filled in

To the To the Complet

Dele of Injury (Month, Day Year) 28c. Injury at Work? 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier

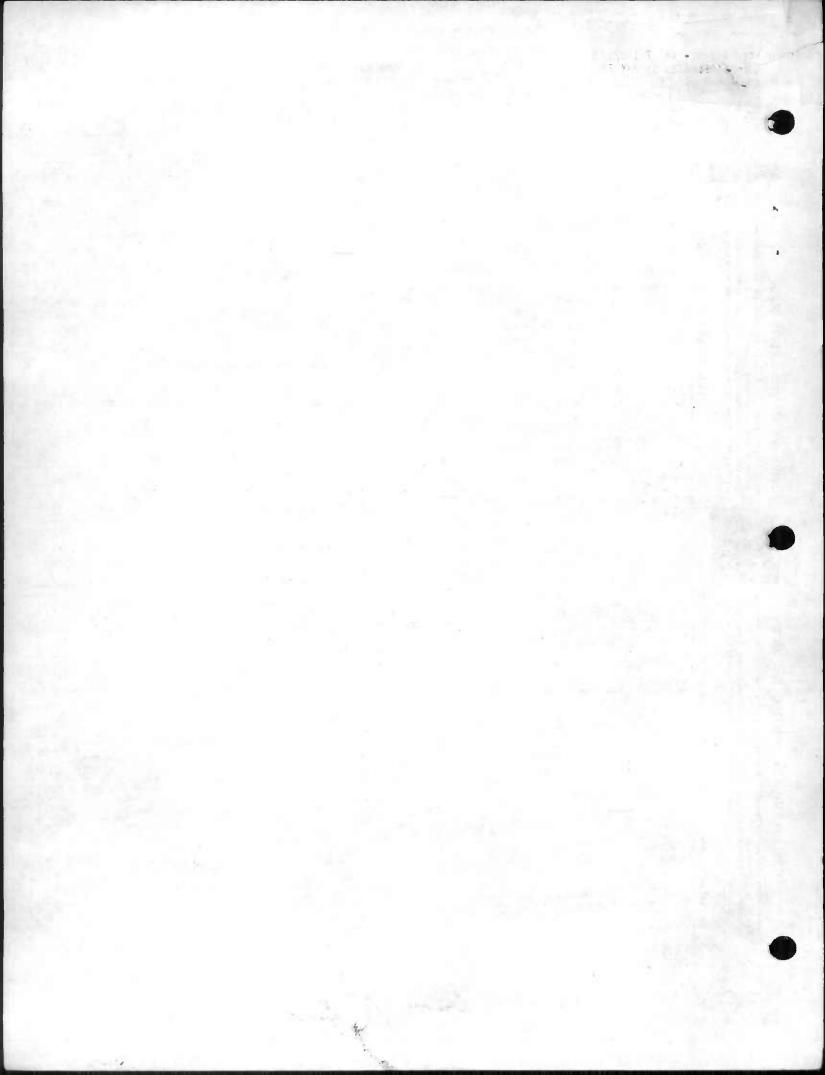
29b. Signature end tills of Certifier 29d. Date signed (Month/Day, Year)

31. Dete filed (Month, Day, Par Pegistrer's signeture 25

MEGANESTE MARNAPOW

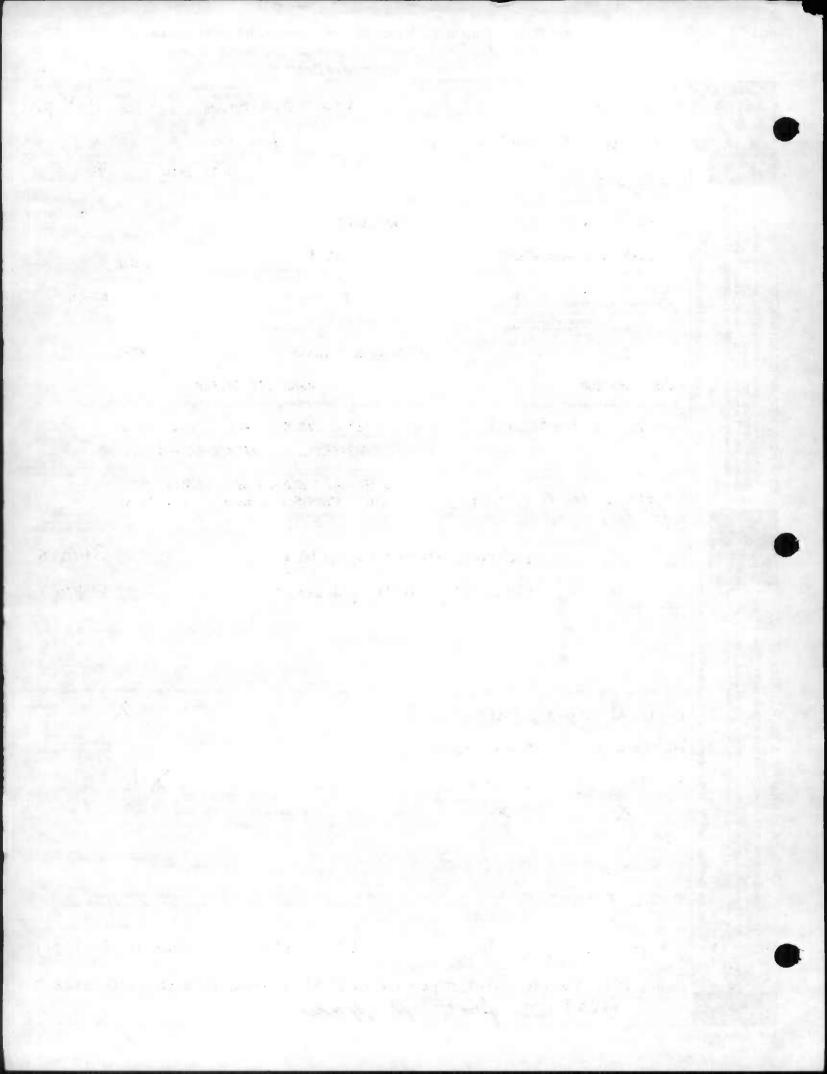
State Registrar

Medical



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 18 **Physician** Mortor George February 23 2000 Pm /Medical 4e Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County oi Death Examiner John Hopkins Bayview Medical center Battimore Inder 24 Hrs. 8. Date of N/A 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral** Deys 110 M 2□ F Months Hours 85 03-17-1914 Va Director 218 01 1616 Usual Residence of Decedent the Menylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1316 ELLWOOD AVENUE 21213 Funeral death 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: 11. Meritel Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. BLACK by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within . Department of Heelth and Mentel Hygiene. Important: if item 27 is merked other than \* to any lojury or other traumetic event, tra Mac. page. Elementery/Secondery (0-12) College (1-4or 5+) FURNACE REPAIRMAN STEEL 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be WILLIE MORTON HARRIETT WATSON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 3629 DOLFIELD AVENUE, BALTO., MD. 21215 HARRIETT GHEE/DAUGHTER 20e. Method of Disposition 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, Stete BALTIMORE CEMETERY 1 XBuriel 2 Cremetion 3 Removel from State 2/29/2000 BALTO., MD. 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility
JAMES A. MORTON & SONS F.H., INC 21 Signature of Funerel Service Licenses ames a. dem 1701 LAURENS ST. BALTO., MD. 21217 23a part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart tailure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medicai Immediate Cause (Fine) . Ischemic cardiomyopathi disease or condition resulting in death) Examiner Due to (or es e consequence ot): Examiner Coronary artem 10 years artery diseas physician end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760 8 Physician/Medical Due to (or es e consequence ot): 80 986 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the 3 Probably 4 Unknown 6 1 Yee 2 No Stenosis Critical aortic Division of Vital Records. þ 24b. Were eutopsy tindings eveileble prior to 24a. Wes en eutopsy performed? Completed bronchogenic carcinoma completion of cause hes failure, acute 2 100 1 ☐ Yes 2 ☐ No renal funerel director, Be 25. Wes case reterred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 Yes 2 No 28c. Injury at Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time oi 28d. Describe how Injury occurred Certification: Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation or Attand after death Director: 6 Could not be determined 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 24 hours To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Hospital WIN worke Bathmore, MD lower Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Julia Miller 21,2000 Mering 12:35pm Feb. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blakehurst Towson Baltimore If Under 24 Hrs. If Under 1 Year Months Deys 8. Dete of Birth (Month, Day, Year) Feb. 6, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Hours 1 □ M 2 1 F 216-80-6633 Yrs. 89 PA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Towson 1 Yes XXNo Baltimore Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1055 W. Joppa Road 21204 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: white py 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) homemaker home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Arron Miller Blanche M. Burkemeyer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intormant's Name/Relationship (Type, Print) 120 E. Baltimore St. Baltimore, MD 21202 Donald R. Mering-son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Fairview Cemetery 2/25/00 Allentown, 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212 23e. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) Cardiopulmonare Examiner Acute Renal 10 days Fa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): Heart Congestive Due to (or as a consequenca of): )iserse 050005 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss pontributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? utoneons completion of cause of death? ( )astro in testina! 2 12 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical axaminer?

1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 DNetural 1 Yes 2 No 2 Accident 6 Could not be 3 Suiclde 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide

ician and burial-transit Box 68760

**Funeral** 

Director

rel', or items 23a or 28a-f show Examiner must be notified at

"naturel", or

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturally or other traumatic event."

**Physician** 

/Medical

Examiner

the Maryland

72 hours after

21215-0020

Completed by Physician/Medical Be Certification: To

or Attending Physician: after death. Diractor: After this certifica • Funeral Di Medical To the Hosp within 24 ho To the Fune completaly fi

P.O. Records, Division of Vital

> State Registrar

**DHMH 16 Rev 6/95** 

31. Dete tiled (Month, Day, Year) FEB 252

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steled. 29d. Date signed (Month, Day, Year) 22-00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

William D.McConnell 500 W. University Pkwy.Bal.MD 21210

0

29b. Signeture and title of certifier

32. Registrer's Signeture

n n n ) '-} Ţ 71 7 7 9 CELL A SET OF THE COL of other sections of the section of C C

#### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2000 230 Month Febusy James Herbert Mc Donald 21 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death N/A Baltimore Union Memorial Hospital If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 10M 20F Hours Yrs. 217-24-1159 70 April 21,1929 Maryland Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21211 USA 4318 Grandview Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 (Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2) No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Donut Bakery Baker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eva Milstread James M. Mc Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Mc Donald Grandview Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) (Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) 2/25/2000 Woodlawn, Maryland Cemetery Woodlawn 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Fur neral Service Licensee 3631 Falls Road, Baltimore, Maryland Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or many failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lymphons PROJACUS +VE 3 manns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Hyperamology coma 24b. Were autopsy findings available prior to CVA WIR LEST benigly 24a. Was an autopsy performed? completion of cause of death? SMAPH reput 1 Yes No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Examiner Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ehow.

288-1

Peges 1 and 2 should be filed within 72 hours attar deeth with nent of Hastin end Mental Hyglene.
unt: if item 27 Is marked other than "natural", or thems 23s or ury or other thaumate avent, the Medical Estimina must be a ray or other thaumate avent, the Medical Estimina must be

Department of Important: If eny Injury or Dife.

**Physician** 

/Medical

21215-0020

Baltimore, Maryland

Box 68760,

Division of Vital Records, P.O.

Attending Physician:

reast be notified at

Director

Completed by

Physician/Medical by Completed 8 25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

physician and the burial-transit USB 88 signed by the attending I this certificate Certification: To funeral : After ! al or Attendin s after death. I Director: Aft of In by the fur

To the Hospital or A within 24 hours after To the Funeral Directompletally filled in by Medical

Registrar

FEB25 **DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

29b. Signature and little of cortified

ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Worth Colvent spect Ball, mucho 2/2/8

28c. Injury at Work?

TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 □ Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital: Palinpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Agrees B Hower

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

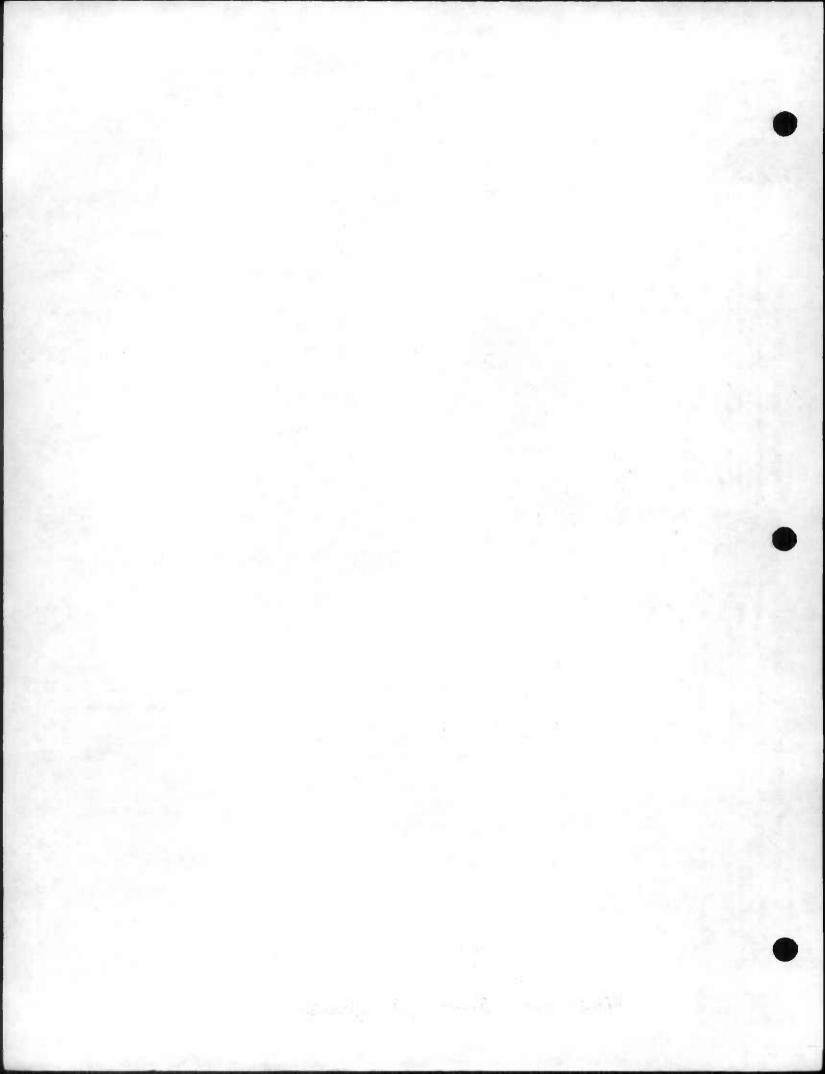
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB **Physician** 2000 03 8:20 PM MCHale hora-hec /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7994 Brown Bridge Road Highland Howard If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1□ M 2□ F Yrs 48 Director 219-48-0449 24, 1951 Maryland Usuel Residence of Decedent r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryla: 1 ☐ Yes 2 ☐ No Director Spring Montgomery Silver 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or herrs 23a or 20904 USA 1106 Briggs Chaney Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yas X☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Applied Physics Lab Buyer 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If them 27 is marked off lury or other trausmilic even jury or other trausmilic even Be Mary Louise Patton William Ralph Love 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Brandon P. McHale/son 1106 Briggs Chaney Rd., Silver Spring, MD 20904 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/04/00 Baltimore, Metro Crematory, Inc. meganiti any int 21. Signature of Pyneral Service License 22. Name and Address of Facility Cremation Society of Maryland, McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Batween Onset and Deeth **Physician** Immediate Causa (Final diseasa or condition rasulting in death) /Medical Metastatic Common Bile Duct Carcinoma **Examiner** Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting In death) Last pue Due to (or as a consequance of): physician s the burial Box 68760. Physician/Medical Due to (or es e consequenca of): 88 980 P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 has 1 Yas 2 No 1 Yes 2 No certificate or Attending Physician: funeral director, 26. Place of Death (Check only one)

DOUTHOUSE S

To A Desidence 6 Dother (Specify) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Pending Investigation 1 Natural 1 Yes 2 No To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, afc. (Specify) 3 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier February, 17, 2000 RES-000 3rmo 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) Johns Hopkins Hospital Abenaa Brewster 31. Date filed (MonF. EB 2 5 32. Registrar's Signature State 2000

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 2000 23 20 PB Ernestine Nesbit /Medical 4e Facility Nema (If not institution, give street end number) www. or Location of Deeth 4c. County of Deeth Examiner 5 ALTIMORE HOSPITAL AGNES If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) **Funeral** Days Hours Months 1□ M 25 F Yrs. Director 219-30-5169 20 S.C Usual Residence of Decede 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore 10e. Streef and Number 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be Herne 23s or U.S.A. 2923 West Mosher Street 21216 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2X No 1 ☐ Never Merried 2 ☐ Merried 8 Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th grade Housewife na Home 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be the Pages 1 and 2 should be threat of Health and Mertal rant: if them 27 is marked o 2 Arthur Nesbit Elizabeth Heyward 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Daughter d 836 Cooks Lane, Baltimore Md

20b. Pleca of Disposition (Name of cemetery, cremetory or other plece)

Data 20c. Location Elaine Steele Fitzgerald altimore, 20c. Location - City or Town, Steta 20a. Method of Disposition Murial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet 2/28/00 Owings Mills, Md 21. Signeture of Funerel Service Licansee 22. Name end Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Maryland enter the mode of dying, such es cardiac br respiratory errast. 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner on SESTINE physician and s the burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last DILATED Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 88 Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 Yee 2 No 3 Probably 4 Onknown RENA 2 à 24b. Ware autopsy findings available prior to Completed 24a. Wes an autopsy completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No funerel director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DInpatient 0 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending or Attending after death. 1 Yes 2 No Investigation 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled in 112 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dele signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) HOSPITAL YOU CATON AVE, BALTIMOKE A-LEXANDER AGNES JOHNSON, FEB 2.5 2000 32. Registrer's Soneture Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

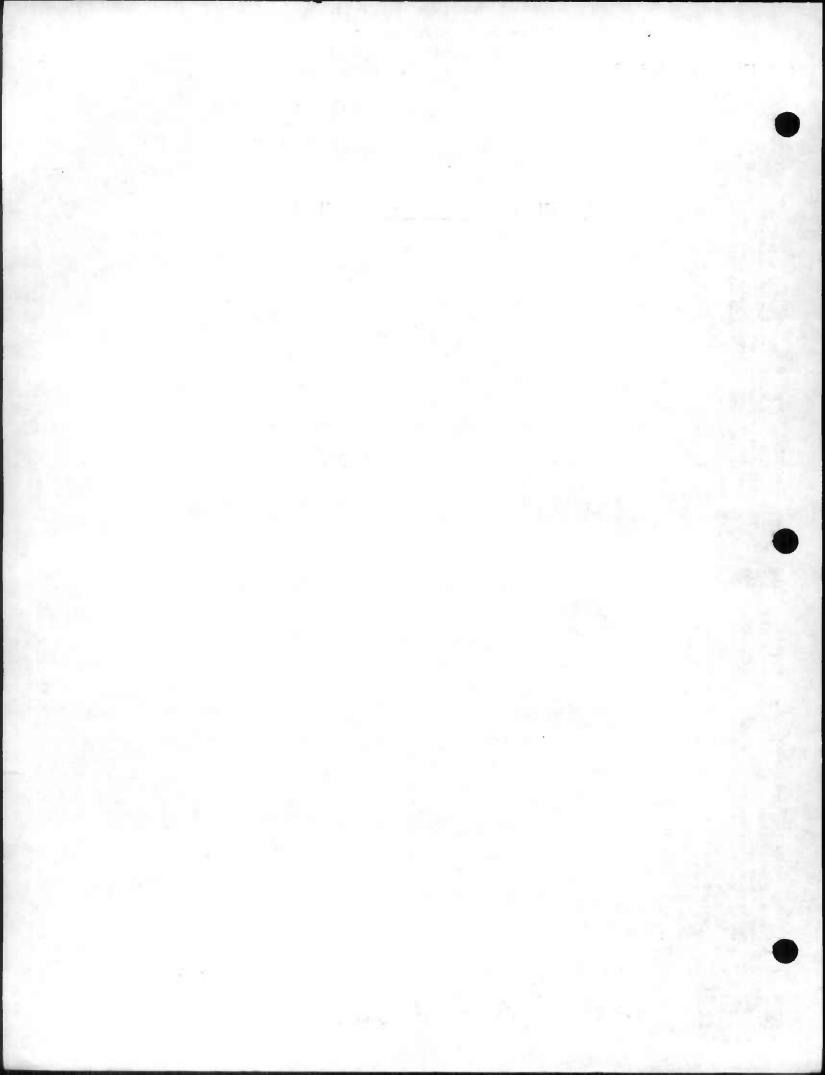
AMENDED ITEM 10b, 10c PER FH G780 2/25/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 21, 2000 LOUISE NUDLEMAN 4:50AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner NORTH OAKS HEALTH CENTER BALTIMORE BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JAN 29, 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (fn yrs. last birthday) **Funeral** 1 □ M 2 K F Months Days Hours 298-09-3566 86 Yrs. 1914 Director Usuel Residence of Decedent 10b. County BALTIMORE 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 No BALTIMOE BALTIMOE 280-7 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 725 MT. WILSON LANE Name 23a 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - American Indian. Bleck, White, etc. the Medical Examiner hours after 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 "nafural", or 1 ☐ Yes 2 No Specify: by WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Uauel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be h and Mental in its merked of **ISADORE** SCHMERIN HELEN LENA YEGLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 I WENDY ROSEN / DAUGHTER 202 E. NORTHERN PAKWAY - BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) important: if the any injury or off price 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 2/23/00 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Foreral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical mohor **Examiner** Physician/Medical Examine The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): lenot Box 68760. Due to (or as e consequence of) resulting in death) Last USB 88 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗗 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of fnjury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C
completely filled To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 30375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Rd: Balkman, 70 31. Date filed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

2 5 2000

32 Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death PURCELL Month Physician WELLA Feb. 21, 2000 6:30pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Daeth Examiner 1025 Abbott Ct. Baltimore If Under 1 Year If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days 10 M 20 F 245-62-5633 80 Yrs Director NC **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at MD NA Baltimore XIXYas 2 No Director 10a Street and Number 10f, Zip Code 10g. Citizen of What Country? 1025 Abbott Court 21202 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yas or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 72 hours after Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baitimore, Maryland 21215-0020 \*natural', or 1 Yes 20 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentel Hygiene. Important: if item 27 is merked other than "nath any injury or other traumatic avent, the Medica page. Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Housewife in home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 Will Purcell Coranelius Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21234 1811 Wycliff Road Baltimore, Maryland
20b. Place of Disposition (Name of cometery, cremetory or other place)

Date 20c. Location - City or Town, Stell Patricia Cooper 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 02-26-2000 Dundalk, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 eren March F.H. East 1101 E. North Ave. 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart leiture. Let only one cause on each fine. Approximate Interval Between Onset and Death **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical 10 Cances 6 MONTHS Examiner Due to (or as a consequence of): Examiner physician end the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Phyaician/Medical Due to (or as a consequence of). 980 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? Records, P.O. 4 deteched signed by the 1 Yes 2000 3 Probably 4 Unknown g 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed peen certificate has 22710 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 25 No Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28d. Describe how injury occurred 27. Manper of Death 28b. Time of tnjury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Netural 2 Accident or Attending 5 Pending investigation after death. Director: After d in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide Mospital 24 hours a Funeral C pelli 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 FEBRUARY 23, 2000 MP 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MICOL ROTHMAN, MO JOHNS HOPKINS HOSPITAL BAYTMORE, MD 21205 31. Date lited (Month, Day, Year)

**DHMH 16 Ray 6/95** 

State

Registrar

FEB 2 0 2000

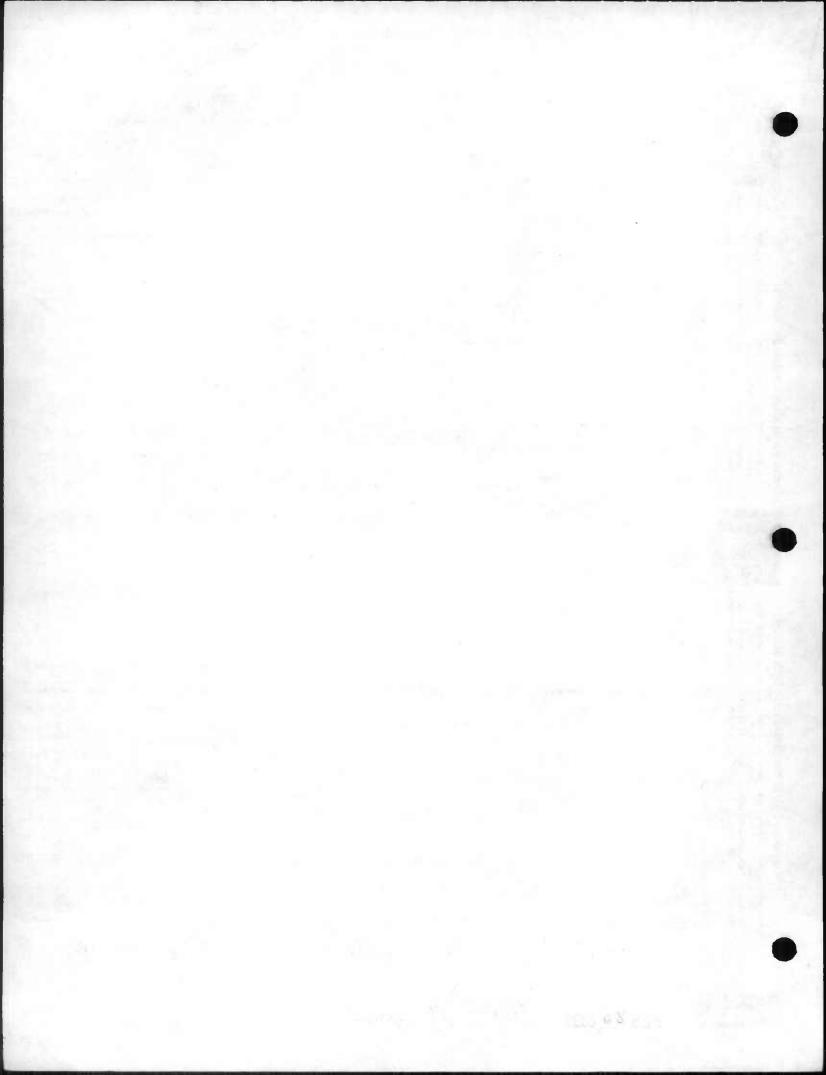
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32. Registrar's Signature

## Please Type or Print in Black indelibie ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day **Physician** Margaret Brown Prucino February 6:30 AM 20, 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Howard 7845 Grassey Garth Elkridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 20 F 81 222-01-9567 June 24, 1918 Delaware Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2√ No Director Elkridge Maryland Howard 280-1 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ŏ 7845 Grassey Garth 21075 U.S.A. Berra 23s Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 X Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Nestith and Mental Hy
Important: if item 27 is marked other
any injury or other traumatic event Be Michael Brown Buchanan Maru 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Sharon Johnson (daughter) 7845 Grassey Garth, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 🕱 Removal from Stete All Saints Cemetery 2/24/00 Wilmington, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimuner Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarvel Between Onset end Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical METASTATIC RECTAL Cancer YCAK Examiner Dua to (or es e consequance of) Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initialed events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, by 24b. Were autopsy findings eveilable prior to Completed 24e. Was an autopsy performed? completion of cause of death? page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only ona) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) ş 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 0 NW MUS cause of death (Item 23a) (Type, Print) Koutrelakes 11065 Little Paturent Pky Columbia mo 21044 NICHOLAS W. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State FEB 2 5 2000 Registrar

F



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle 1 ast) 2. Dete of Deeth Physician -Month 2 Bessie /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner NUVSINS 1591 OVIEM Foure NA 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthpiece (State or Foreign Country) **Funeral** Deys 1 M 2 F 215-22-7707A 73 Yrs. Director 04 - 06 - 26MD Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at MD Director NA Baltimore X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 1300 E. Lanvale Street Apt 609 21213 items 23a USA death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. be filed within 72 hours after 1 Never Married 2 Married b Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: Black "natural". Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) House of Worstex Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Heelth and Mental Hygiene Important: If Item 27 is marked other that any injury or other traumetic event, the pages. Custodian Clothing Factory 8th Grade 17. Fether's Neme (First, Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Abraham Quickley Annie Parks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 2106 E. Hoffman Street Baltimore, Maryland Margaret Crowell 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 € Burlai 2 Cremetion 3 Remove from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Kings Mem. Pk. Cem. 02-26-2000 Randallstown, 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a Pert1. Enter the diseese, or conshock, or heart feilure. List op death. Do not enter the mode of dylng, such es cardiec or respiratory errest, Approximete Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Finei diseese or condition resulting in deeth) Examiner Physician/Medical Examiner ettending physician end for use es the bunel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest P.O. Box 68760, Due to (or es e consequence of): ed by the er Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown be det Records. ò pege 2 should Completed 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 1 Division 1 Naturei 5 Pending investigation To the Hospital or Attendiwithin 24 hours efter deeth.
To the Funeral Director: A completely filled in by the fi deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 I Homicide 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner steted. Medical 29a. Certifier (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Deie signed (Month, Dey, Year) 30. Name and eddless of person who completed cause of deeth (Item 23e) (Type, Print)

HICHOYS

32. Registrer's Signature.

Rd Columbia Md 21

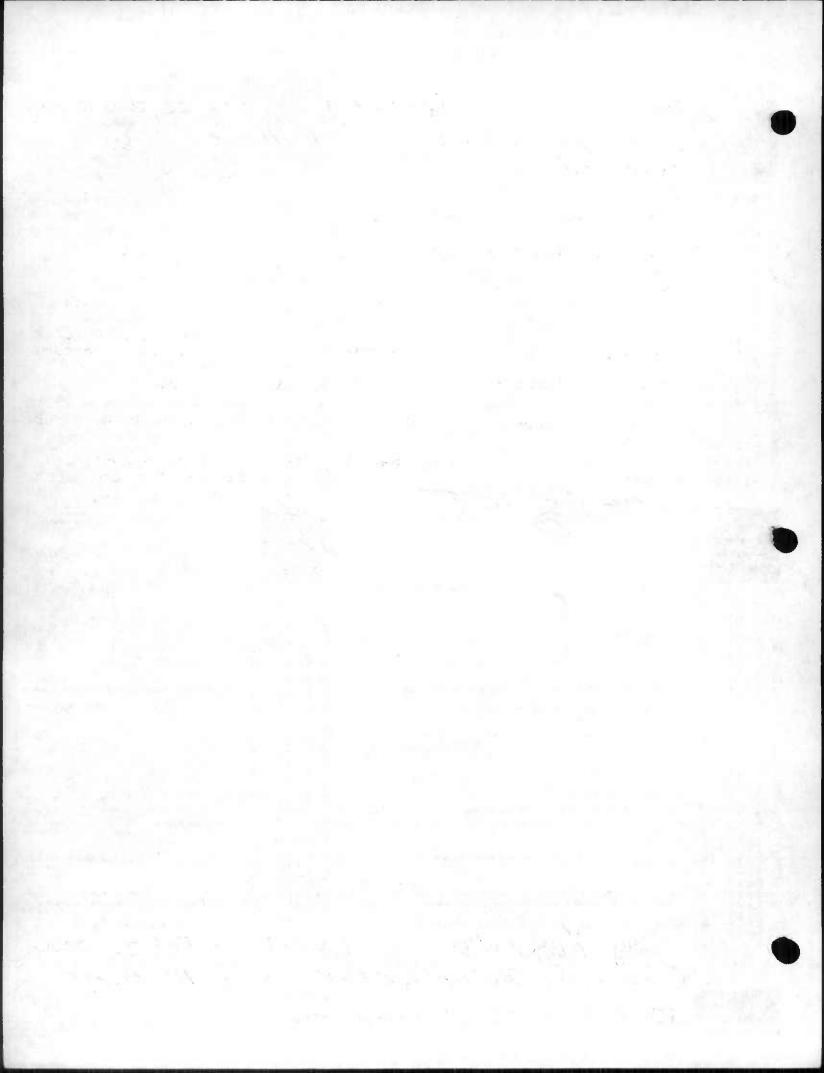
Registrar DHMH 16 Rev 6/95

State

KG21061

31. Dete filed (Month, Day, Year)

FFB 25



sician	1. Decedent's Neme (First, Middle,	Last)				Death		2. Dete of Dea			3. Tima of Death
edical	DANIEL	EDWARD	RINGG	OLD SR.				Month FEB	Dey 17 20	Year 00	6:30pm
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ral tor	5. Social Security Number  214-10-9864  Usuel Residence of Decedent	. Sex 7. Age	(In yrs. last bir	Months	Days	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Dey OCT 9	Year)	9. Birthpia Counti NEW	JERSEY
	10a. Stete 10b. County 10c. City, Town or Location									10	d. Inside City Limits
tor	MARYLAND HARFORD HAVRE DE GRACE										1 ☐ Yes 🏋 No
Directo	10e. Street and Number 10f. Zip Code							1	ry?		
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by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried  3 XX/Idowed 4 Divorced	Armed Forces?	1 ☐ Yes 2 ☑ No If Yes, Give		<ul> <li>Wes Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F</li> <li>1 ☐ Yes 2 ☐ You Specify:</li> </ul>				ecify Yes or No- Rican, etc.)  14. Rece - American Ind Black, White, etc.  Specify:  BLACK		
	15. Decedent's	Education	ation 16a. C		el Occup	pation			16b. Kind of Business/Industry		
Completed	(Specify only highest s Elementery/Secondary (0-12)	grade completed)  College (1-4or 5-		(Give kind of wo	ork done	during most	t of worki	ng			
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	21. Signeture of Funeral Service Lig	**	IMI CAI	22. Name e	nd Addre	ess of Fecilit	у	-23-00			
	1/2 /w. 1.15	2000				BROW		MMUNITY	FUNERA	L HOM	E PA- ABERDEE
	23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications thet caused ly one cause on each lin	the death. Do						est,		Approximete Intervel Between Onset end Death
	Immediate Cause (Finel disease or condition		118001	12010							
	resulting in deeth)	θ	Due to (or es e	consequence of)						1	
Examiner											
хап	Sequentially list conditions.  Due to (or as e consequence of):										
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	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	c								-	
cal	cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last	c	Due to (or es e	consequence of):					23,		
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Ca	thet initiated events	■ d			cause gi	ven in Pert I.		23b. Dld to	bacco uss coi	ntributs to	the causs of death
Ca	Ceuse (Disease or injury that initiated events resulting in death) Last	■ d			cause giv	ven in Pert I.			obacco uss con	ntributs to	
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by Physician/Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	■ d		n the underlying		9			es 2 No	3 Prob	re autopsy tindings ileble prior to apletion of cause
by Physician/Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	■ d		n the underlying		ven in Pert I.		1 ☐ Y	es 2□ No in autopsy med?	3 Prob	re autopsy tindings ileble prior to upletion of cause eath?
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Be Completed by Physician/Medical	Pert II. Other significant conditions  COROLLO VASUU  THY REA TENSION  AUGUST A	d. contributing to death but AR	th not resulting in  ENT  MYOCAF  COPU	the underlying of the underlyi	USA	RCY O	Of Deeth	24a. Wes e perform	on autopsy med?	24b. We ava com of d	re autopsy findings ilebile prior to upletion of cause eath?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 18 per fh G780 2/25/00 yg Certificate of Death 1, Decedent's Name (First, Middla, Last) 2. Date of Death Day Year **Physician** February 17, 200 cation of Death | 4c. dounty of Death Geral dINE OSC 07:00A,M 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City

If Under 24 Hrs. 8. Deta of Birth
(Month, Day, Year)

JULY 19, Hopkins The Johns 5 Tospita 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (Stata or Foreign Country) **Funeral** Months Days 1□M 2□F 168-18-6750 76 Yrs. 1923 Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/A Yas 2 No BALTIMORE Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 3704 HUDSON ST. 21224 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ≥ ☐ YNo If Yes, Giva Year or Datas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiere. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8TH 18. Mother's Nama (First, Middle, Maiden Sumame) Mary Margaret Baltimore, Maryland 17. Fathar's Nema (First, Middle, Last) 88 Pages 1 and 2 should be nent of Health and Mental FREDERICK CLAUDE FREDERICK 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Health a it flows 27 is or other tre 1709 LESLIE ROAD, BALTIMORE, MD. 21222 FRANK PAUL ROSCH, SR./SON 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata Department of Important: If any injury or page. 2/22/2000 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMTERY 21. Signature of Funarel Service Licensee 22. Nema and Address of Facility CHARLES S. ZEILER & SON, INC. 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on aech line. BALTIMORE, MD. 21224 Approximate Interval Between Onset and Death Physician /Medical Immediate Causa (Final PNEUMONIA 6 days diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Due to (or as a consequence of): Box 68760. physician Dua to (or as a consequence of): USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? has 1 Yes 2 No 1 Yas 2 No or Attending Physician: Be 25. Wes case refarred to medical examiner? 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Division 5 Pending invastigation death. 1 TYes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifie

State Registrar

31. Data filed (Mbnth, Day, Year) FEB 2 5 2000

Patt

30. Nama and address of purson who completed cause of death (Item 23a) (Type, Print)

32 Aggistrar's Signature G. Sporks

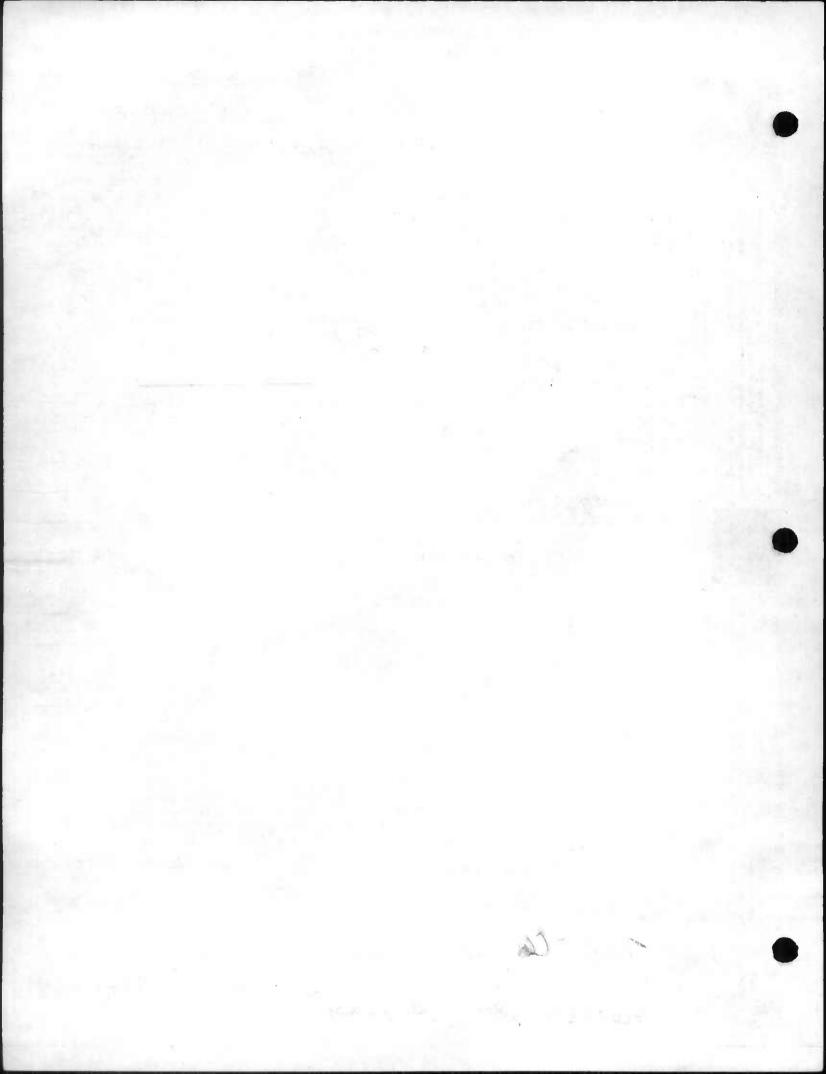
fe St. Baltimore, MD

KES-000

February

2128

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** ebruary 2000 /Medical ation of Death 4b. City. Town, or Loc 4c. County of Death not institution, give street and number) Examiner 8. Date of Birth Month, Day, Year) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 MM 2 □ F Yrs 121 **Director** Usual Residence of Decedent with the Maryland 10d. tnside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/2/4 10 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

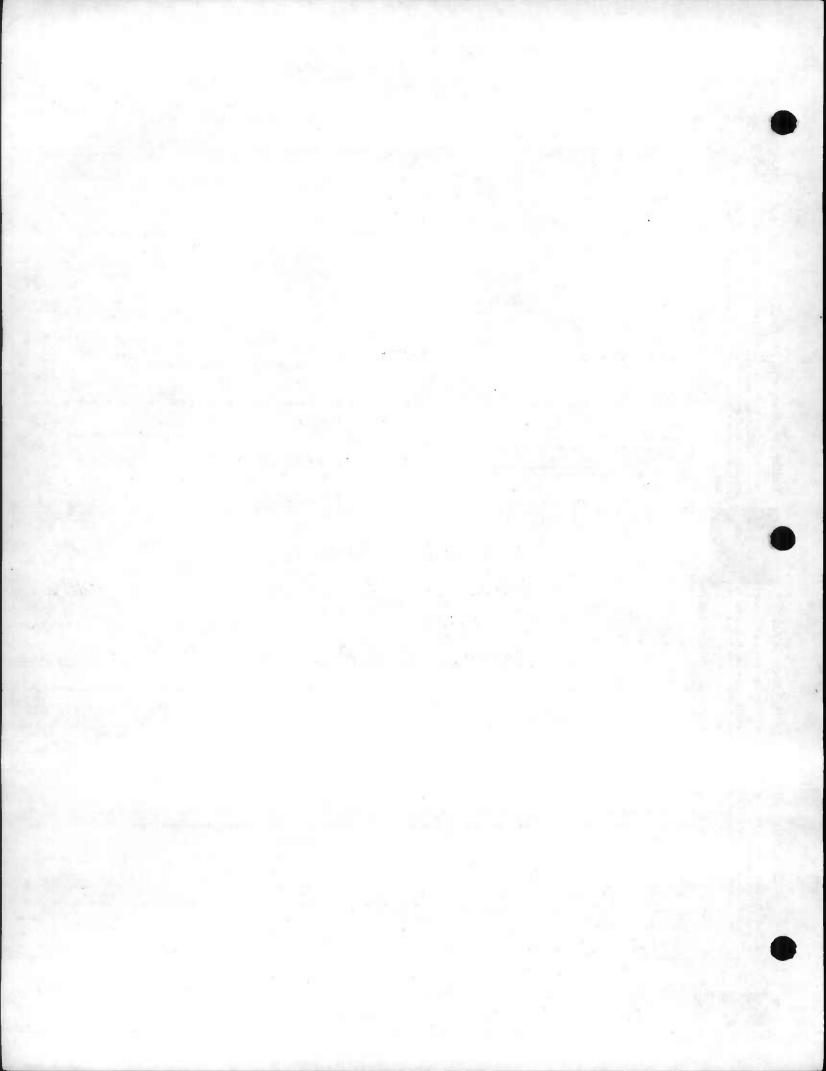
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours eftar of Department of Haalth and Mental Hygiane. Insportant: If item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Union 301 Local Elementary/Secondary (0-12) College (1-4or 5+) II17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Ka 4nna DIOBERGER August 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City of Town, State, Zip Code) 1929 E', B 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Feb 26 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) emete 2000 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility 3 Vanis Funckal Chape Ral 8800 Harterd Part 1. Enter the disease, or complications that caused the death. shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiretory arrest **Physician** Courcei Prostati tmmediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s tha buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): certificeta be axed Box 68760 Physician/Medical Due to (or as a consequence of): 88 950 for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings evallable prior to 24a. Was an autopsy performed? Completed completion of cause of death? pega 2 hes 2 0 No 1 Yes 2 No 1 Yes cartificeta or Attending Physician: funaral director, Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 28b. Time of Aftar Natural 5 Pending investigation tnjury 1 Yes 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3066 aluquen February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Streeth TRIPURAW Harborsbuck, Harbord Rel; Balliwell, (Ko 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State FEB 25

**DHMH 16 Rev 6/95** 

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Year **Physician** 20, 23:30pm Janie M. Ross Feb. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Dete of Birth (Month, Day, Year) **Funeral** Months Hours 1 M 2 F 214-54-2507 50 Director 06-04-49 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at YAYas 2□No Director Baltimore MD NA 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 645 N. Kenwood Avenue 21205 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, Whita, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□Yes 2□No Specify: Specity: à 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nant of Haalth and Mentai Hygiene. Int: If Item 27 te marked other than "ity or other traumedt avant, me Has Elizabeth Konne Elementary/Secondary (0-12) College (1-4or 5+) Nurse 11th Grade NA Agency 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Lonnie Boyd Evelyn Randall 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 19a. Informant's Name/Relationship (Type, Print) 645 N. Kenwood Avenue Baltimore, Maryland Sharon D. Ross 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Voshell Mem, Gardens 02-25-2000 Dundalk, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a/Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture/ List only one cause on each line. Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician a Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) = 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed 1 Yes 2 No 1 ☐Yes 2 ☐ No. of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 를 27. Manner of Death 1 K Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division Attanding 5 Pending investigation Injury after death. Director: All d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò To the Hospital of Within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contil-100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simpler, 808-810 CONKLING-ST. BALTO MID 31. Date filed (Month, Day, Year) 32, Registrar's Signeture State 25 Registrar



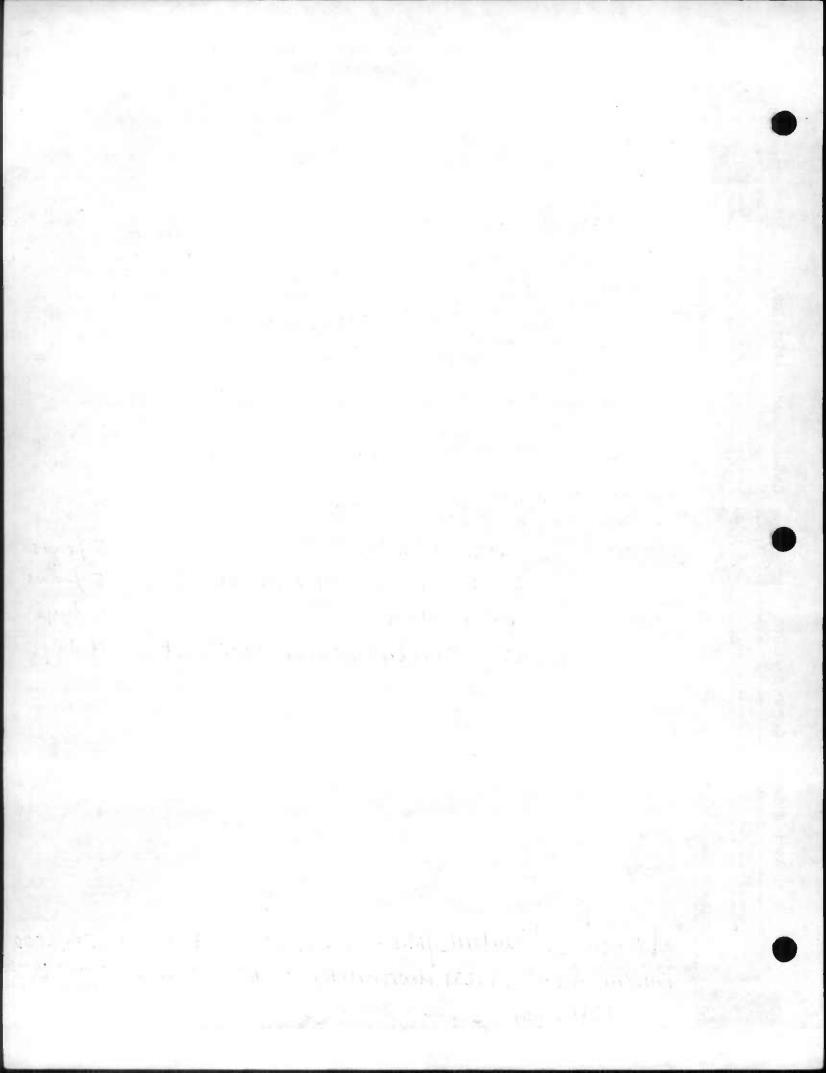
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** RECTOR CALVIN 2:22PM ZBRUMM 21, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner (CANDAUS TOWN CENTER HOSP ITAL BALTIMONE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 100 M 20 F Yrs. 218-12-2242 Director Aug 8 1922 Usual Residence of Decedent the Maryland 10b. County 10s State 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 ☐ Yes 2 No Director 288-1 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? ò 23 B Oak Grove Drive 21220 "natural", or items 23s IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Morital Status Bleck, White, etc. 72 hours after 1 Never Married 20XMarried Valley 2 No If Yes, Give vland 21215-0020 1 Yes 2 No Specify: White Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CabDriver Royal Cab Company 10th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H anti if Item 27 is marked off lury or other traumatic even 8 Leroy Rector Sr. Geneva L Davis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leroy Rector Jr. / brother 10326 Vincent Road White MArsh MD 21162 altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 2/25/2000 Department Baltimore MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Essex a. or complications that caused the dual Do not enter the mode of dying, such as cardiac or respiratory arrest, ere 23a. Part I. Enter the disease shock, or heart failure Approximete tritervel Between Onset end Deeth **Physician** Immediate Cause (Finel /Medical HOUR MYOCARDIAZ IN FARCTION disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner YEARS DISEASE AMEMOSCLENSTIL CARPIOUASCULAR physicien end the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ex 68760. Physician/Medical Due to (or es e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Onknown DEMENTIA ADVANCED SENILE Records. à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? pega 2 1 ☐ Yes 2 ☐ No 1 ∏Yes 2 ∏ No of Vital Physician: funeral director, 8 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient → RP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To this s 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division Attending 1 SNatural 5 Pending investigation after deeth. 1∏Yes 2∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 3 4 Homicide e Hospital or 1 24 hours after Funeral Dire 15 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier To the Hosp within 24 ho. To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of continue 047587 115 EBRUARM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANDAUS TOWN TNE MO OLD COUNT ROAD MD 540) 22: Registrar's Signature State 200cks

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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F3F8	Dungas .	٥٠	29c. License number D - 40201				February 15th, 2000 VE., F-24, (MAITHESBUR MD 20886				
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State Registrar	31. Data filed (Month, Day, Year) FEB 2 5	32. Registrar's Si		4	la						



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State of Maryland / Department of Health and Mental Hygiene 5 5

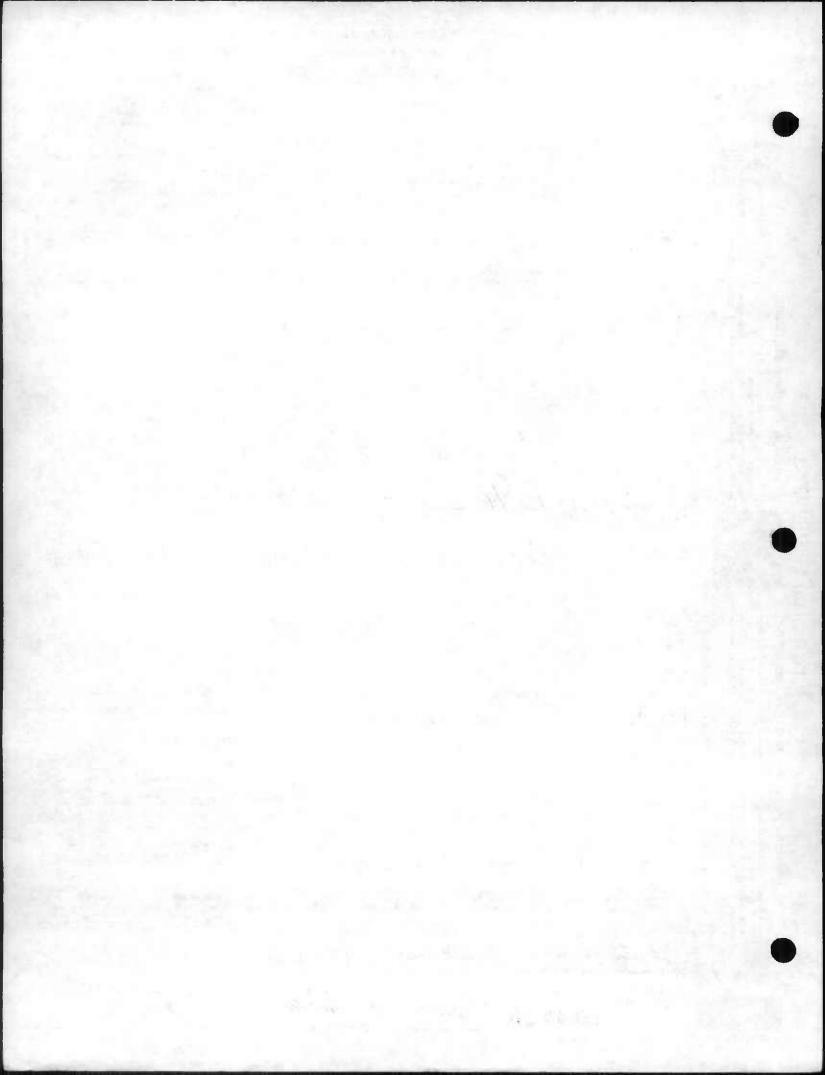
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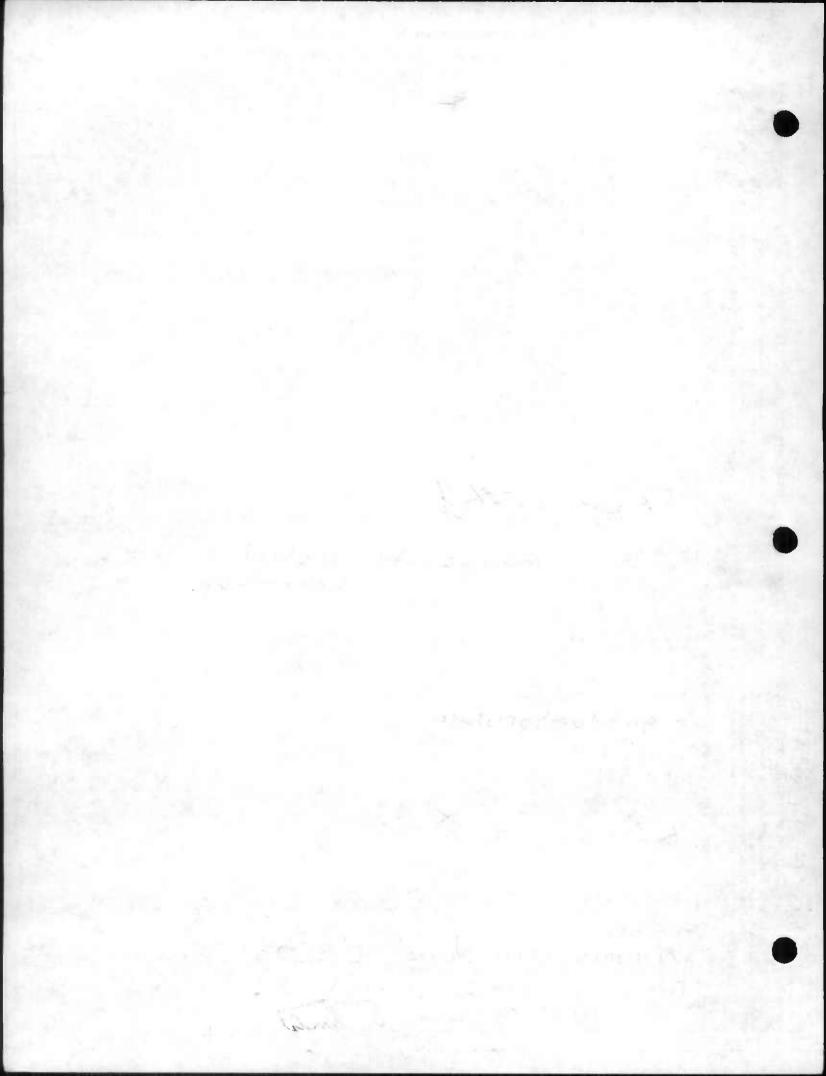
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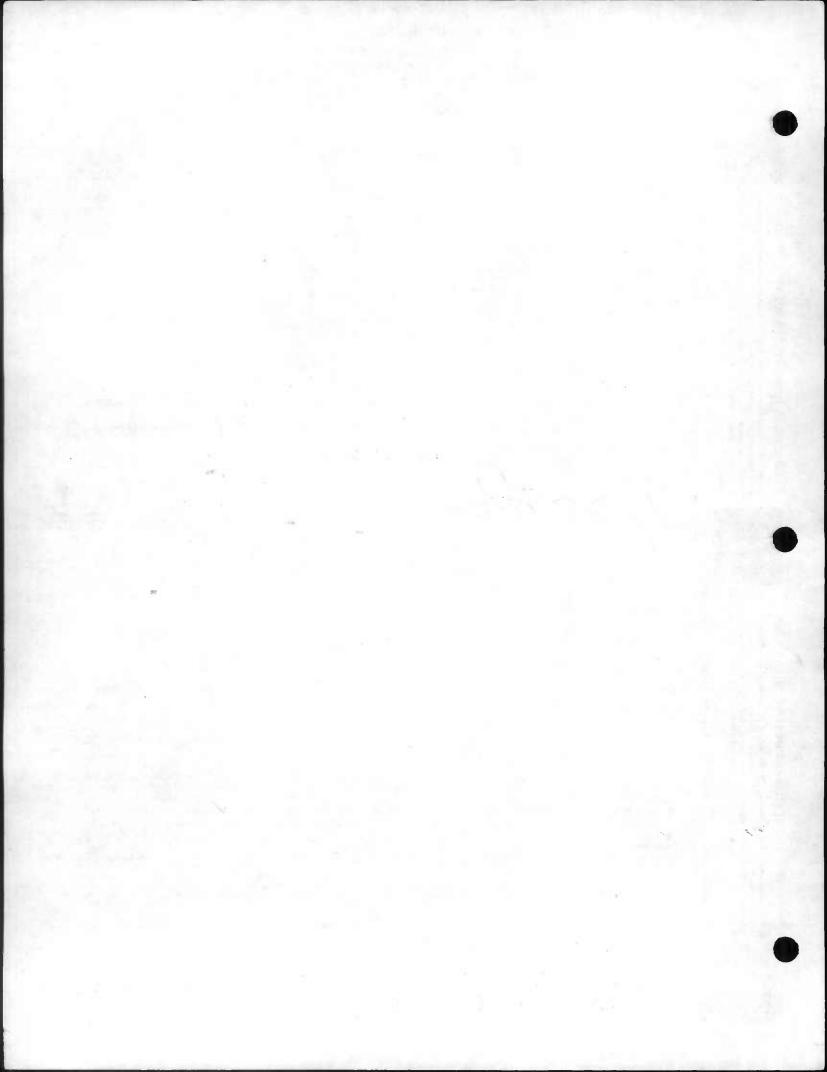
State of Maryland / Department of Health and Mental Hygiene 00 06153

	Certificate of Death	1	Reg. No.							
	Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death						
Physician	Teodulfo G. Ramos	Month FEBRUAF	- ,	0 0410 A.M.						
/Medical		Location of Deeth								
Examiner			40. County of	Douti						
3:	T 447 7 747 1 770	imore								
eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15 Under 1 Yee If Under 24 Hrs. Months Deys Hours Min	. (Month, Day	y, Year)	Birthplace (Stete or Foreign Country)						
ctor	212-92-2488 103 M 2LIF 84 Yrs. 103 Joys 103 Joys	July 2	5, 1915	Philippines						
	Usual Residence of Decedent									
4 .	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
- 5	MD Baltimore Woodlawn		1							
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?						
	6327 Monika Place Apt 605 21207		U.S.A.							
Funaral				14. Race - American Indien,						
5	Armed Forces? If Yes, specify Cuban, Mexican, Puer	nto Rican, etc.)	, etc.) Black, White, etc.							
3	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:  3 Widowed 4 Divorced Year or Dates:		Specify:	Philippino						
Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	orking	16b. Kind of Busin	ness/Industry						
100	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)									
0	4 Maintenance		Westview	Mall						
	17. Fether's Name (First, Middle, Last)  18. Mother's Name		Maiden Sumeme)							
To Be	Antonino Ramos Macar:	ia Gard	des							
-	19e. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street end Number or R	iural Route Numbe	er, City or Town, St	tate, Zip Code)						
	Jesusa Ramos (wife) 6327 Monika Place Ap  20a. Method of Disposition 20b. Place of Disposition (Neme of	Date Date	20c. Location - Ci	MD 21207						
	1 XBurial 2 Cremation 3 DRemoval from State cemetery, cremetory or other pleca)									
	4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery	2/28/00	Woodlawn	, Maryland						
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	itzke Fur	neral Hom	nes Inc						
	1630 Edmondson A									
				Approximate						
	23a. Pert1. Enter the disease, or complications that caused the other. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ic or respiratory or	1001,	Interval Between Onset and Death						
an		Onsot and Doam								
ical ner	Immediate Cause (Finel disease or condition resulting in death)	hours								
	Due to (or es e consequence of): \	1								
edical Examiner	Lenor	c Hade	_							
E	Sequentially list conditions  Due to (or as a consequence of):									
EX	if any, leading to immediate									
28	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as a consequence of):									
edical	resulting In death) Last									
2	d									
18										
/sic	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco uas contribute to the cause of de								
Completed by Physician	Late 1 land - weller.	10	Probably 4 Unknow							
79	11. de 2000 61 20010	-								
8		24a. Wes		24b. Were autopsy findings eveilable prior to						
et		репо	med?	completion of cause of death?						
200										
		101	Yes 2000	1 Yes 2 No						
Be	25. Was case referred to medical araminer? 26. Place of De	eath (Check only o	one)							
To	Hospital:	Home 5 Resid	dence 6 Other	(Specify)						
	27. Manner of Death  28a. Dete of Injury  28b. Time of languary et (Month, Dey Year)  1. Death (Month, Dey Year)  28b. Time of languary et Work?	28d. Describe I	how injury occurred	d						
to	1 Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
flea flea	3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location /	Street end Number	or Rurel Route Number.						
Certification:	3 Suicide 4 ☐ Homicide  28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)  28f. Location (Street end Number or Rurel Ro City or Town, Stete)									
	00.0.4%									
edical	29e. Certifier (Check only 2   Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plec									
8	and manner stated.									
12	29b. Signature and title of certifier 29c. License number	0)	29d. Date signed (	(Month, Dey, Year)						
V	MALLONIA MILLONIA D 3306	5   1	Edwar	C423 700						
	Mame and address of person who completed cause of death (item 23a) (Type, Print)	0 ,		1903,000						
	The same and a decision of parasit with completion cause of code (interest cod) (1996, Fillit)	1	7 7	122 - 00						
	Deleting Alexandra Con Veer 1	er Col	C 20	MUNDIC.						
State	J. Date filed (Month, Dey, Year) 32. Registrer's Signature			er.						
istrar	PEDRUL PRINCE D. May !!									



State of Maryland / Department of Health and Mental Hygiene

Morting   Day   Year   Section   Section   Name (Irran Assistation, pive street and number)   45. Ho.   Description   45. Ho			
Second Seconds   Part   Control	:15AM		
Social Security Number   217-24-4039   10   20   10   10   10   10   10   10			
The state of the second of the	itete or Foreign		
1.   1.   1.   1.   1.   1.   1.   1.	ide City Limits		
1. Martiel Status 1. Decadent Education 1. Decadent Education 1. Decadent Education 1. Decadent Education 1. Decadent Status 1. Dec	Yes 2⊠No		
Type   Specify:   Sp			
Sequentially list conditions	an,		
20e. Method of Disposition   128 Burled   2   20c. Location   3   Removed from State   20c. Location   5   20c. Decation   5   5   20c. Decation   5   5   5   20c. Decation   5   5   5   5   5   5   5   5   5			
20e. Method of Disposition   128 Burled   2   20c. Location   3   Removed from State   20c. Location   5   20c. Decation   5   5   20c. Decation   5   5   5   20c. Decation   5   5   5   5   5   5   5   5   5			
20e. Method of Disposition   128 Burled   2   20c. Location   3   Removed from State   20c. Location   5   20c. Decation   5   5   20c. Decation   5   5   5   20c. Decation   5   5   5   5   5   5   5   5   5			
20a. Method of Disposition   20b. Place of Disposition (Name of complete), crematory or other place)   20c. Location - City or Town, St.   20b. Place of Disposition (Name of complete), crematory or other place)   2/25/00   Baltimore, Mary   2/25/00   B			
Physician / Medical Examiner  Due to (or as a consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  CHE  Demonds on Avenue, Catonsville, MD 2  Approach of Althemet's type  Demonds on Avenue, Catonsville, MD 2  Approach of Caucer  Due to (or as a consequence of):  CHE  Due to (or as a consequence of):  23b. Did tobecco use contribute to the consequence of a consequenc			
Physician Medical Examiner  Due to (or as a consequence of):  Due to	al Homes, Inc.		
Part II. Other significant conditions contributing to death but not resulting in the undertying causa given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the undertying causa given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the undertying causa given in Part I.    1   Yea   20 No   3   Probably	months		
Dementia of Alzheimer's type  24a. Wes an autopsy performed?  24b. Were autopsy performed?  24b. Were autopsy performed?			
	prior to		
1 Yes 2 No 1 Yes	2 No		
1   Yes   2   No   No   No   No   No   No   No			
1   Yes 2   No   Hospitel: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 8   Other (Specify)   27. Menner of Deeth   28a. Dete of Injury   28b. Time of   Injury   Work?   28d. Describe how Injury occurred   Work?			
25. Was case referred to medical examiner?	Number,		
28e. Place of Injury - At home, ferm, street, fectory, office  28f. Location (Street and Number or Rural Route  28g. Certifier (Check only one)  29g. Certifier (Check only one)  29g. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  29g. License number  29g. Dete signed (Month, Day, Y	iuse(s)		
Bruce M. Many Mn D25861 2/22/00			
30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)  716 Maiden Choice Lane Balto Maryland 21228 Bruce R. McCyrdy  State  31. Data filed (Month, Day, Year) 5, 2001 32. Register's Signeture	mo		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 23. 2000 **Physician** Bethel Lee Scarlett 11:45AM /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 273 Elizabeth Ave. Lansdowne Baltimore # Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10M 20F 82 Yrs. 217-10-1465 Director Aug. 6, 1917 West Virginia Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Maryland Baltimore Lansdowne Director 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 273 Elizabeth Ave. 21227 U.S.A. death v Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, permit. Fages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural", or its any injury or other traumatic evant, the Mental Exercises. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White p 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Nursing Assistant Health Care 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be 0 Mark Boswell Lula Dora Wetzel 19a. Informent's Neme/Raletlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shereen Shadle, daughter 273 Elizabeth Ave. Lansdowne, MD. 21227 20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State semetery, cremetory or other place) 1 ₺ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Glen Haven Cemetery Glen Burnie, MD 02-26-00 4 Donetion 5 Other (Specify) Signature of Funerel Service Moensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 Part. Entit the common or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth Physician Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner Sequentielly list conditions, if any, leeding to immadiate causa. Entar Underlying Cause (Diseese or injury that initieted events resulting in death) Last buriai-tran Due to (or es a consequence of): ending physician a Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown 8 by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed page 2 should 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No certificate Vital director. 25. Wes casa referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Medicai Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA of this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After Attending 1 Neturel 5 Pending investigation death. 1 Yas 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completaly filled in by the f 2 ☐ Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 THomicida 29a. Cartifian Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaner stated. (Check only 29c. License number 29b. Signature/a 29d. Date signed (Month, Day, Year) 24356 2000 900 Cator 30. Neme and addrass of person who comple se of deeth (Item 23a) (Type, Print) Concer 0 Wat Win crtica snes Centr

State Registrar

31. Dete filed (Month, Dey, Year)

FEB25

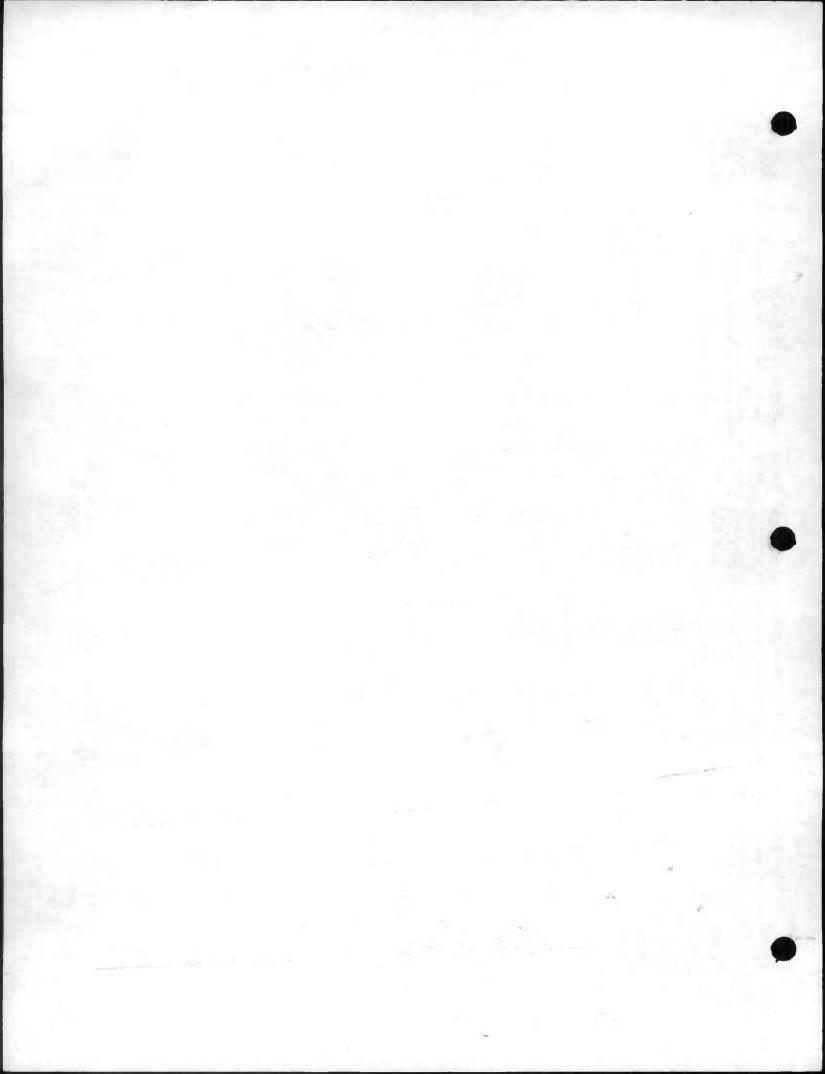
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**DHMH 16 Rsv 6/95** 

Scarlott

**ORIGINAL** 

32. Registra s Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death nt's Name (First, Middla, Last) Year **Physician** 2000 6.10 Am /Medical ty Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner a monton If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Months 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days 1□ M 殿 F Hours 217-24-4957 71 Director PARKSLEY, 07-04-28 **Usual Residence of Decedent** 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 show MD N/A 1ŒYes 2□No Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 21225 U.S.A. 611 ROUNDVIEW ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (M No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, atc. filed within 72 hours after Hygiene. Oher then "natural", or the 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: **Black** 4 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if them 27 is meriked other the BEAUTICIAN SELF EMPLOYED 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Be DAISEY DRUMMORD LEE TURNER 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5614 FRANKFORD AVE, BALTIMORE, MD 21206 JOAN STANLEY, DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-25-00 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL 21. Signature of Funeral Syrice Licens 22. Nama and Addrass of Facility Howell Funeral Home 4600 Liberty Hghts. Ave Balto.Md 21207 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner attending physicien and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital director, Be 25. Was casa refarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA thia funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 2000 30. Nama and address of person who comp of death (Item 23a) (Type, Print)

State

Registrar

HEY 13

31. Data filed (Month, Day, Year)

FEB 25

32. Registrar's Signature



Sandy of the sandy

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Month **Physician** ANTHONY SIMMONS 2:30am FEBRUARY 15,2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1741 GORSUCH AVE BALTIMORE ff Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex X□ M 2□ F 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 213-60-3177 46 Yrs. 03-05-53 Director BALTIMORE Usual Rasidence of Decedent the Maryland 10a. Sfata 10b. County 10c. City, Town or Location 10d. inside City Limits or 28a-f show 1 X Yas 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä harra 23a 1741 GORSUCH AVE 21218 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian Black, Whita, atc. hours after Never Married 2 Married BLACK altimore, Maryland 21215-0020 netural, or 1 ☐ Yas 2 PNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. other than "n vent, the Med Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED MECHANIC 8 permit. Pages 1 and 2 should be the Department of Health and Mental Hys important: If them 27 is marked other any Injury or other traument other 2006. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Sumama) Be JAMES LEE SIMMONS PAULINE SIMMONS To 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3122 HOWARD PK AVE, NALTIMORE, MD 21207 PAULINE SIMMONS, MOTHER 20b. Place of Disposition (Nama of cematary, crematory or other plece) Data 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MOUNT ZION CEMETERY 2-22-00 BALTIMORE, MD 22. Nama and Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23s. Part1/Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Death **Physician** /Medical Immediata Causa (Final inknown diseasa or condition rasulting in death) Examiner Examiner 11 MA ettending physician end for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): 17 68760 SYNDROME WASTING Physician/Medical Dua to (or as a consequence of): Box ( Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by th 1 Yee 2 No 3 Probably 4 Unknown Records. þ should 24a. Was an autopsy performed? Wara autopsy findings available prior fo Completed completion of cause of death? page 2 certificata 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: director, 25. Was casa refarred to medical axaminer?
1 ☐ Yes 2 ② No 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 AResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manger of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Division After 1 Natural 5 Pending invastigation 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and fitta of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death from 23a) (Type, Print)

State Registrar DANIELA WOLDE

31. Data filed (Month, Day, Year)

FFB 2 5 2000

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32. Registrar's Signatura

DHMH 16 Rev 6/95

100/ CATHEDRAL ST, BALTIMORE, MD, 2/20/



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :30AM 20 /Medical do 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner HMORE ala 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2□F Months Days Hours Min -9619 217-22-9619 Usual Residence of Decedent Yrs. Director NOV. 16 10a State 10h Counts 10c City Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21234 0 Funerai 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Hyes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) nomo LUNKNOWN 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth ar Important: If Item 27 is eny injury or other trau Bladold C. Salle Communication of Disposition 1 Disposition 3 Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Feb. 26 2000 4 ☐ Donetion 5 ☐ Other (Specify) Baotist Church Como 21. Signature of Funerel Service Licensee 22. Name end Address of Facility EVANS FUNLFAL Chapel 23a Port I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e conse Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events continued to the continued of Due to (or es e con Physician/Medicai that initiated events resulting in death) Last Due to (or es e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? pege 2 s 1 Yes 2 X No 1 Yes 2 No 25. Wes case referred to medical examiner? 1 Yes Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Dentural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

that the death certificete be axecuted P.O. Division of Vital Records. Attanding Physician: n 24 hours after death. Ne Funeral Director: Aft pistely filled in by the fur 5 To the Hosp within 24 hos To the Fune compiately fi

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Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene.
Int: If Item 27 Is marked other then "natural", or ite

Baltimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

State Registrar

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31. Dete filed (Month, Day, Year) FEB & 5

29a. Certifier

(Check only one)

29b. Signeture and title of certifi-

30/Name and address of person

32. Registrer's Signeture

e of death (Item 23a) (Type, Print)

**ORIGINAL** 

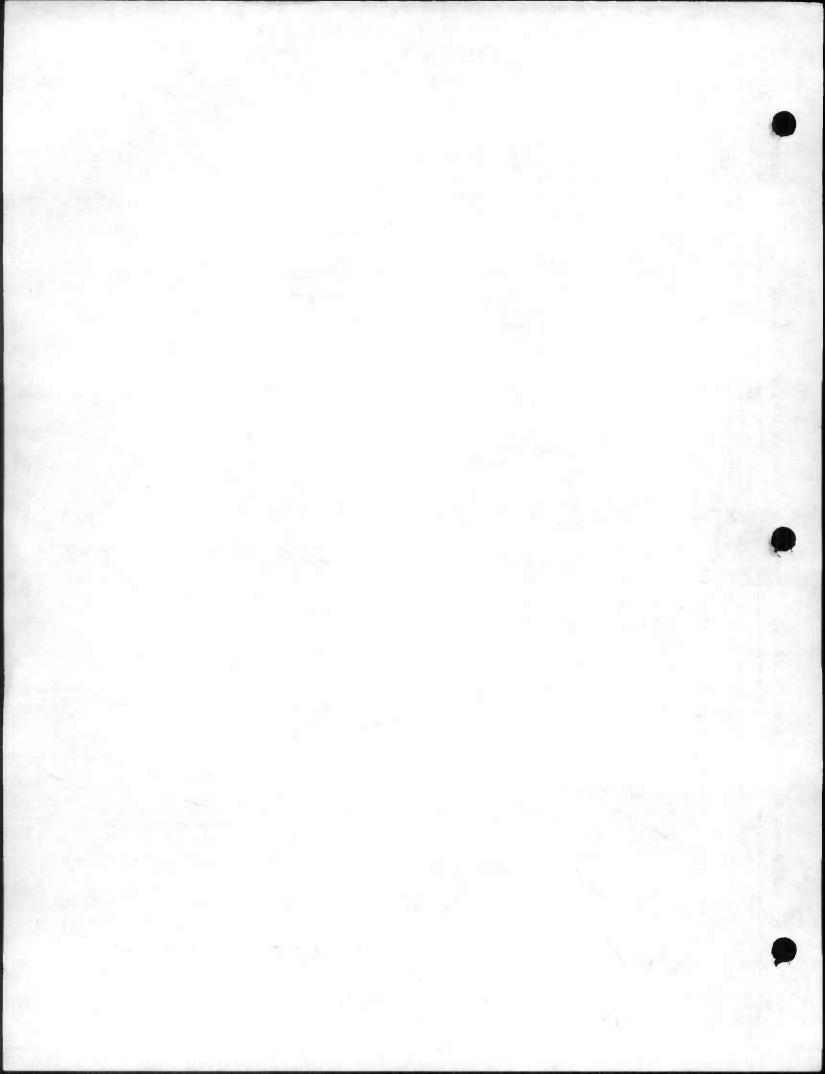
15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** FFB 21, 2000 7 A .::. SAMUEL M. WALTER /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE (HOME) CAREY STREET 1311 S. If Under 1 Year | If Under 24 Hrs. Month, Dey, Year) SEPT 19,1938 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F Months NORTH CAROLINA Yrs. 61 Director 217-34-5608 Usuel Residence of Deceden the Manfand 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23a or 28a-f ahow the Medical Exeminer must be notified at 1 Yes 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with USA 21230 1311 S. CAREY STREET Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 Specify: AFRO AMERICAN 1 Yes 2 No Specify: p Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Mean once. Elementary/Secondery (0-12) College (1-4or 5+) SELF CONTRACTOR IMPROVERMENT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be SALLIE SAMUEL SAITUEL LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 1311 N. CAREY, BALTIMORE, MARYLAND 21230 SAMUEL WIFE LINDA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 2/26/00 LANSDROWN, ND. CE"ETERY 4 Donetion 5 ☐ Other (Specify) ZION 21. Signature of Funeral Service Linenses 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** 2 MOS /Medical Immediate Cause (Finel CARCINOMA diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): (S) signed by the atter P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 31 Probably 4 Unknown 1 Yea 2 No Records. Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ 10 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 8 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neture 5 Pending 1 Yes 2 No 24 hours after death. investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 D Homicide filled in Hospital 29e, Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 24/00 d address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 25 2000 Registrar

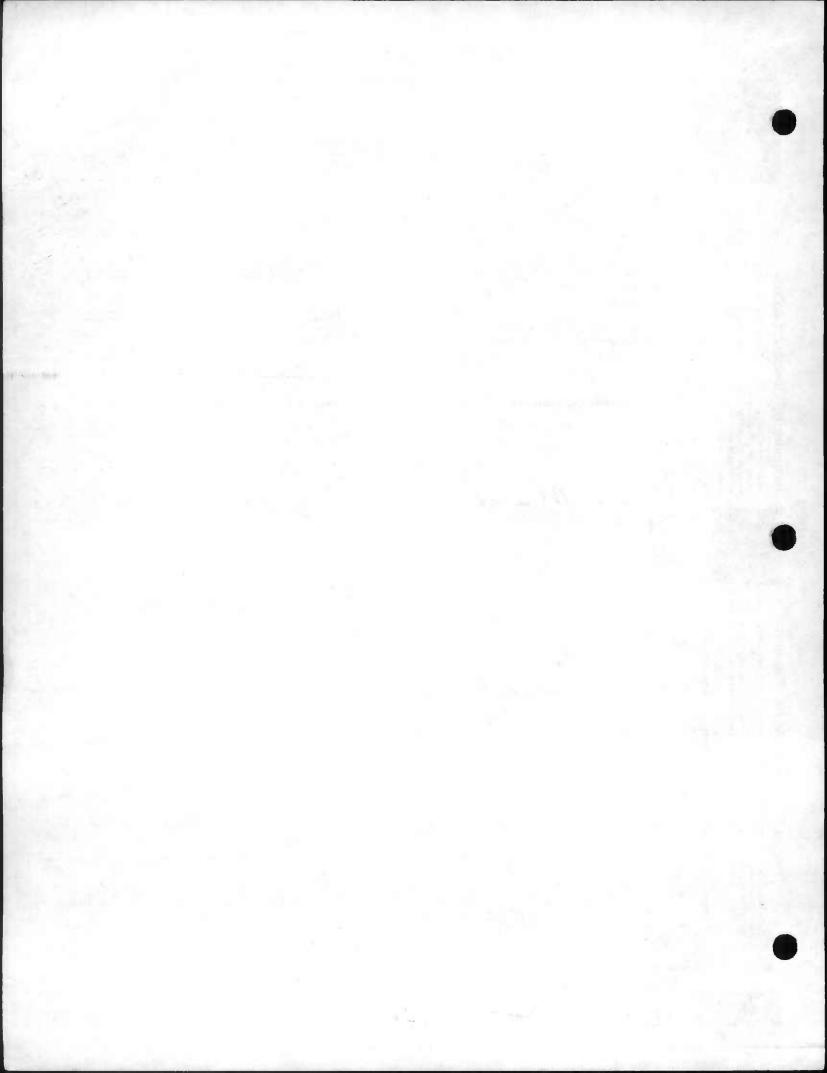
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year Physician KWINSON ANTHONY 2332 FEBRUARY 21 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HUPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 10 M 2□ F Director 219-74-4857 01 M.D. Usual Residence of Decede with the Maryland 10a. State worls 10c. City, Town or Location 10d Inside City Limits Hygiena. Yther than "netural", or iteme 23a or 28a-f ahov ent, its Medical Examinar must be notified at Director 1X Yas 2 No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 3027 Woodland Ave 21215 U.S.A. Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. filed within 72 hours after 1 ☐ Yes Z\\_\No If Yes, Give 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Disabled Disabled na permit. Pages 1 and 2 should be flie Department of Heelth and Mentel Hy Important: if Itam 27 Is marked other any Injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tony Swinson Gene Cost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Woodland Ave #15, Baltimore Md Gene Swinson-Mother 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata Purial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2-26-00 Randallstown, Md 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS 3 WEEKS Examiner Due to (or as a consequence of) PSEUDOMONAS PNEUMONIA 4 WEEKS and that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie HIV 3 YEARS 68760 DISEASE Physician/Medical Due to (or as a consequence of): Box P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, P 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 certificate 1□ Yas 2⊠ No 1 ☐ Yas 2 1 No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 SNatural 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1© Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) (avaring RES-000 FEBRUARY 21, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 JOHNS HOPKINS HOSPITAL BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 2 5 2000

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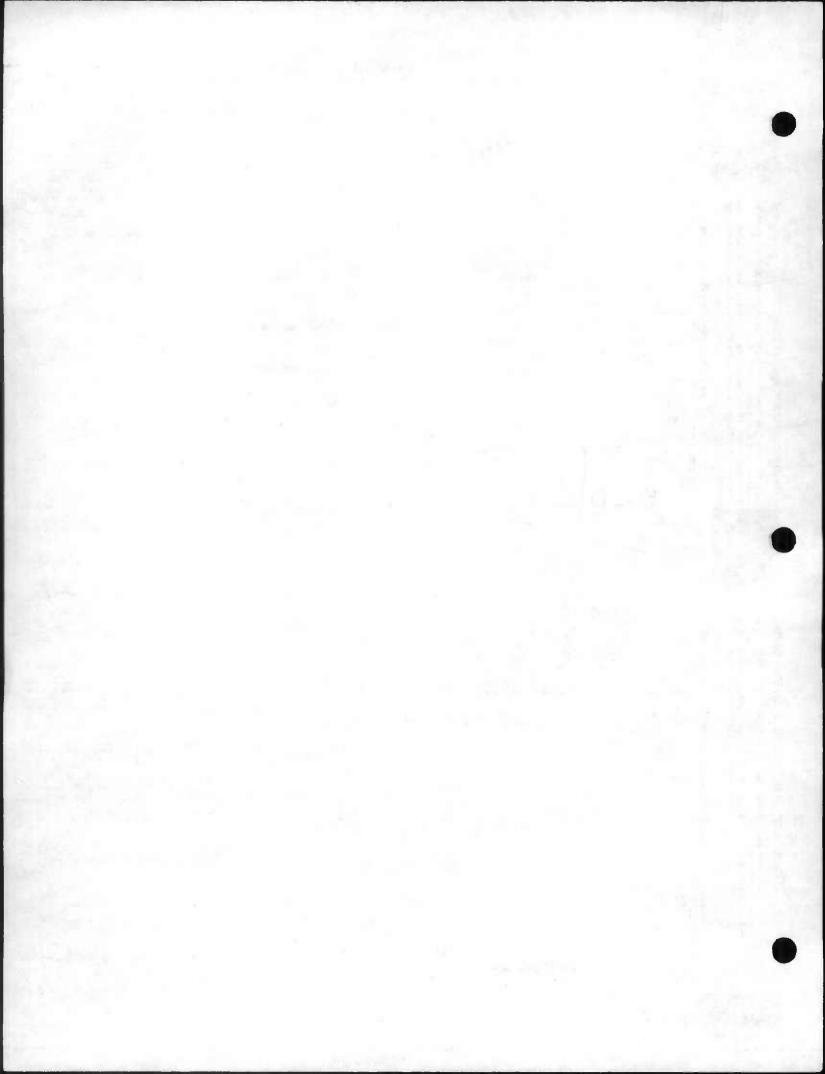


Please Type or Print in Biack indeiibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4b. City, Town, or Location of Death 4c. County of Death 4:00 P.MI Doris N. Schmitt /Medical 4e Facility Name (If not Institution, give street and number) **Examiner** FRANKlin Square 5. Social Security Number 0 6. Sex Has piTAl Cen 7. Age (In yrs. last birthdey) Cen Kose a If Under 24 Hrs BATTIMORE dAle 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1□M 2XF 74 Sept. Director Maruland 213-20-1476 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 4602 Chathord Avenue 21206 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Salesladu Clothing Store Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be 1 and Mental F Henry A. Keim Alice Anna Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) of Health a vt. if Nem 27 is David P. Schmitt (Son) 4602 Chatford Avenue, Baltimore, Maryland 21206 Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood 2/26/00 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ICEMIA Examiner Due to (or as a consequence of): Examiner monia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Dehydration, Dementia, Anorexia Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No Medical Certification: To this 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 24 hours after deeth. 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Phyeician: To, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifie (Check only one) within 2 4 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Marie 30. Name and address of person with empleted cause of death (Item 23a) (Type, Print) 9000 FRANKLIU SquAREDR. BALTIMORE MARYLAND 31. Date filed (Month, Dey, Year) 32. Registrar's Şignature State

Registrar FEB No how DHMH 16 Rev 6/95

FEB 2 5 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dey Month **Physician** 24 2000 0510 Marjorie Porter Starrett February /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M XXF 72 Feb. 8, 1928 Director 579-38-5980 South Dakota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 20 No Anne Arundel Edgewater Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be 3505 South River Terrace 21037 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca · American Indian, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2√XNo If Yes, Give 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 White 1 Tes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Federal Government 12 Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be in iment of Health and Mental H tant. If Nem 27 is marked off lury or other traumatic ever Be Jacob Morris Porter Elizabeth Freeman 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 3505 South River Terrace, Edgewater, MD 21037 John E. Starrett, Sr. (Husband) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 02/28 20c. Location · City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or pose. Lakemont Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2000 Davidsonville, MD 21. Signeture of Funeral Service License 22. Name end Address of Facility Hardesty Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately Approximete fntervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final LUNG CELL WKS diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): USe as signed by the atte Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 a has 1 Yes A No certificate 1 Tyes 2 No or Attending Physician: funeral director, 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Division After Naturel 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Stanley P. Watkins, MD, 900 Bestgate Road, Annapolis, MD 21401

DHMH 16 Rev 6/95

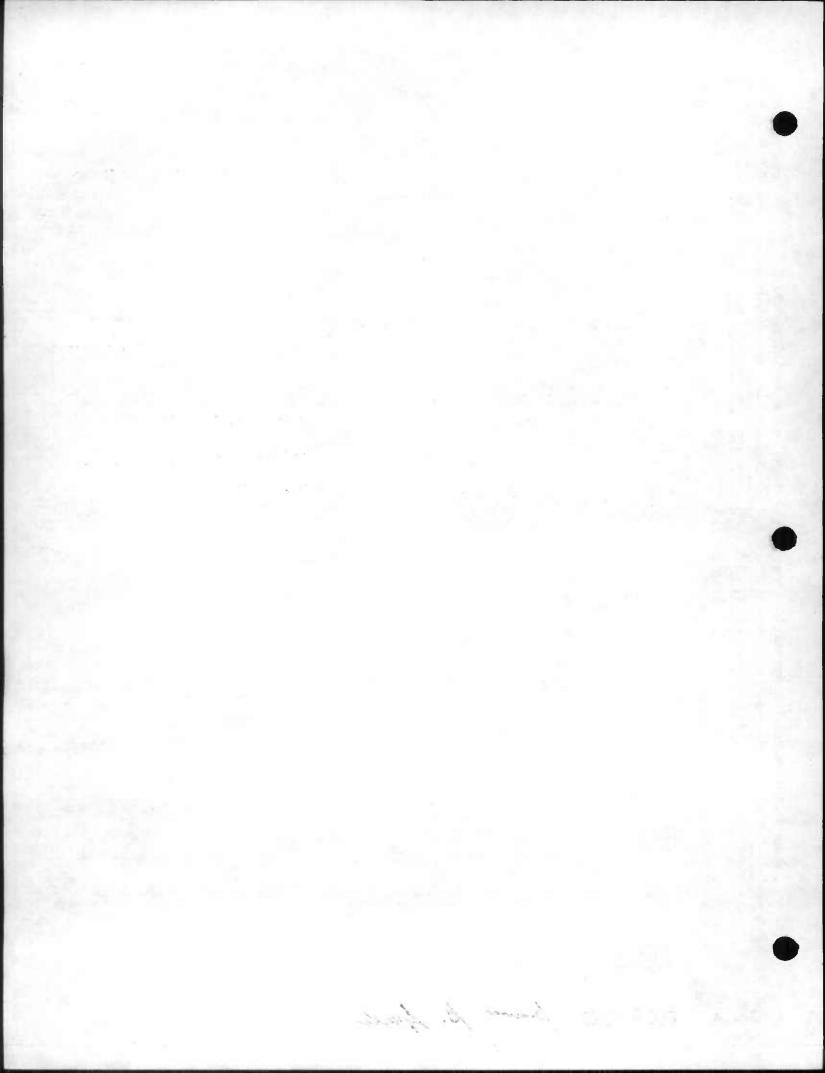
State

Registrar

31. Dete filed (Month, Dey, Year)

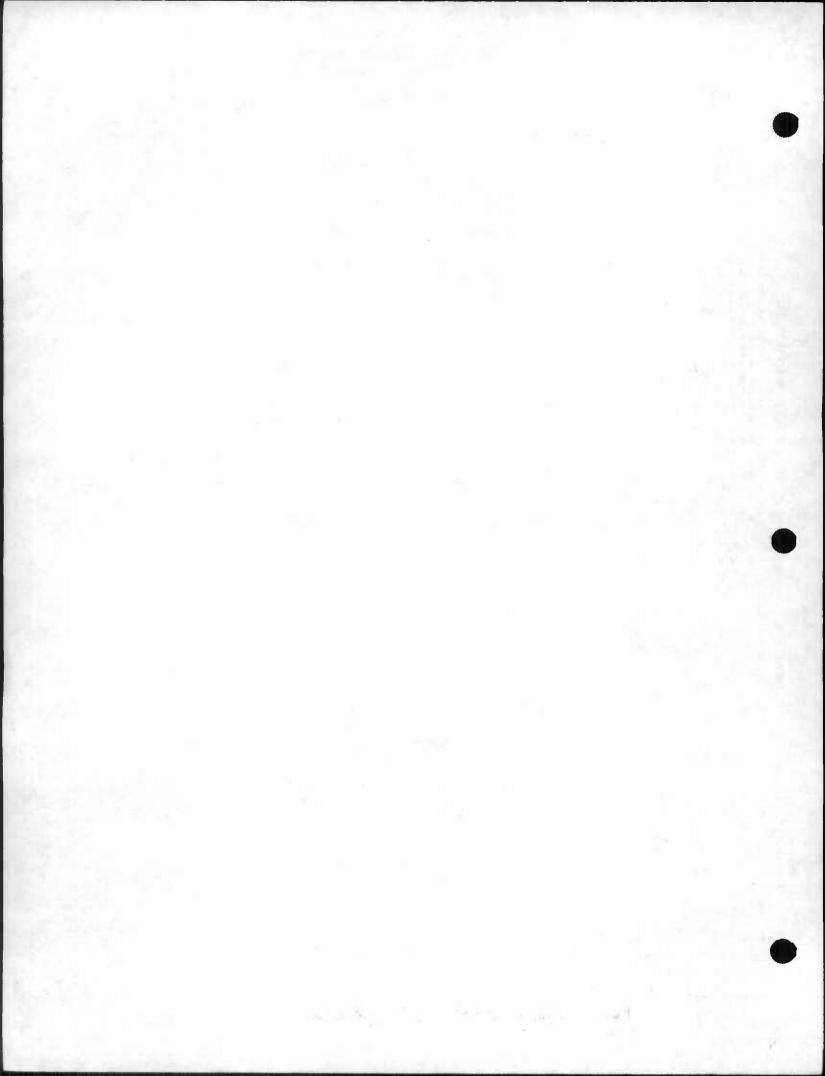
FEB 2 5 2000

32. Registrer's Signeture



## Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

		State of I	Maryland				lealth a Death	and M	lental Hy	giene Reg. No.	00	06163		
Physician	Decedent's Neme (First, Middle LEONARD	, Last)			STULM	AN			2. Dete of Do Month FEBRUA		2000 2000	3. Time of Death 10:30 AM		
/Medical Examiner	4a Facility Neme (If not institution 7907 SEVEN MII	and the second s	er)			4	BALT		ecation of Dear		ty of Deeth			
Funeral Director	5. Social Security Number 212–03–9468	6. Sex 7. 1 2 M 2 ☐ F	Age (In yrs. le 95	st birthdey) Yrs.	If Under Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bi	1, 1905	9. Birth	plece (State or Foreign ntry) MD		
with the Maryland a or 28er show be notified at Director	Usual Residence of Decedent  10a. Stete 10b. County  MD BALTIN	10RE		Town or Lo	E					10d. Inside City Limit 1 ☐ Yes 2 [X]N				
with the or 2 Lbe no		E LANE			10f. Zip	Code	21208	0		U.S.A.	What Cou	intry?		
020 urs after death v at, or terms 23s Examiner must by Furneral	11. Maritel Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decede Armed Force	□ No 1 □ Yes 2			cedent of Hispenic Origin? (Specify Yes or Nopecify Cuben, Mexican, Puerto Rican, etc.)					can Indien, etc.			
1 21215-0020 ad within 72 hours at yours at yours, we than "natural", or ut, the Medical Exam Completed by I	15. Decedent (Specify only highes Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  5+  College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use ratired)  DEVELOPER & OPERATOR					Business/ir			
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event, To Be C	17. Father's Neme (First, Middle, Last)						18. Mother's Neme (First, Middle, Maiden Sumeme)  ANNIE ROSENZWEIO					NZWEIG		
- 5504	19e. Informent's Neme/Reletionsh FRANK T. GRAY		36 S	. CHA	RLES			- #1100		IMORE	, MD 21201			
Fages 1 ment of He ant: If hen ury or oth	20e. Method of Disposition  15 Burial 2 Cremetion  4 Donation 5 Other (St	3 Removel from Sta	ite ce/	nca of Dispo metery, crea ZUK AM	netory or o	ther plea		N) 2	Date 2/23/00	20c. Location	IMORE			
Ball permit Depart import any in	21. Signature of uneral Bervice I	hwar	1				ss of Fecilit					S., INC. MD 21208		
Physician /Medical Examiner  Examiner	23a. Pert1. Enter the disease, or shock, or heart failure. List of the shock of the	eb	Due to (or	es e consec	oli ( quenca of):	h	lo	,	lesea			Interval Between Onset and Death		
6876( 6876)  Itilicete be g physicia es the bur	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	c		Due to (or es e consequence of):										
. 0	Pert II. Other significant condition	but not result	ot resulting In the underlying cause given In Part I.						23b. Did tobacco use contribute to the cause of dea 1 ☐ Yss 2 ☑ No 3 ☐ Probably 4 ☐ Unkn					
require per should	phlemon	ria, pr	arta	le a	mo					s en eutopsy ormed?	a	Vere autopsy findings vailable prior to ompletion of cause of death?		
= F # 8 0	25. Wes case referred to medical	ednies	a	teu	fel	ul	26. Pleci	e of Dear	1 C	Yes 2 No	1	Yes 2 No		
g Physician: ger this certific neral director,	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin	28a. Date of I	atient 2 E	R/Outpaties 28b. Time o Injury		OA Oth	4LIN	ursing Ho		how Injury occ		illy)		
Division or To the Hospital or Attending Physical Structure described or After this complished in by the funeral	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	etion oot be 28e. Placa of	Injury - At hon, etc. (Specify)	ne, farm, st	M eet, factor		Yes 2□	No	28f. Location City or To	(Street end Nur own, Stete)	nber or Ru	rel Route Number,		
n 24 hours in 24 h		Physician: To the be Examiner: On the basis and menner	s of examination											
To the vithing Youth Compile Compile Med	296. Signature and title of certifier	n Shulu	By	0	<u>J</u>	Licens	e number 488	8		29d. Date sign	2//E	Dey, Year)		
10	30. Name and address of person of Allen MTY 31. Date filed (Mgotfs, Dgry, Year)	elman	of death (Item :	18	38	Gx	221	0	rel 1	RN#	35	Batto 2126		
State Registrar	FEB25	2000	Lycular Signature	19	de	ock	2							



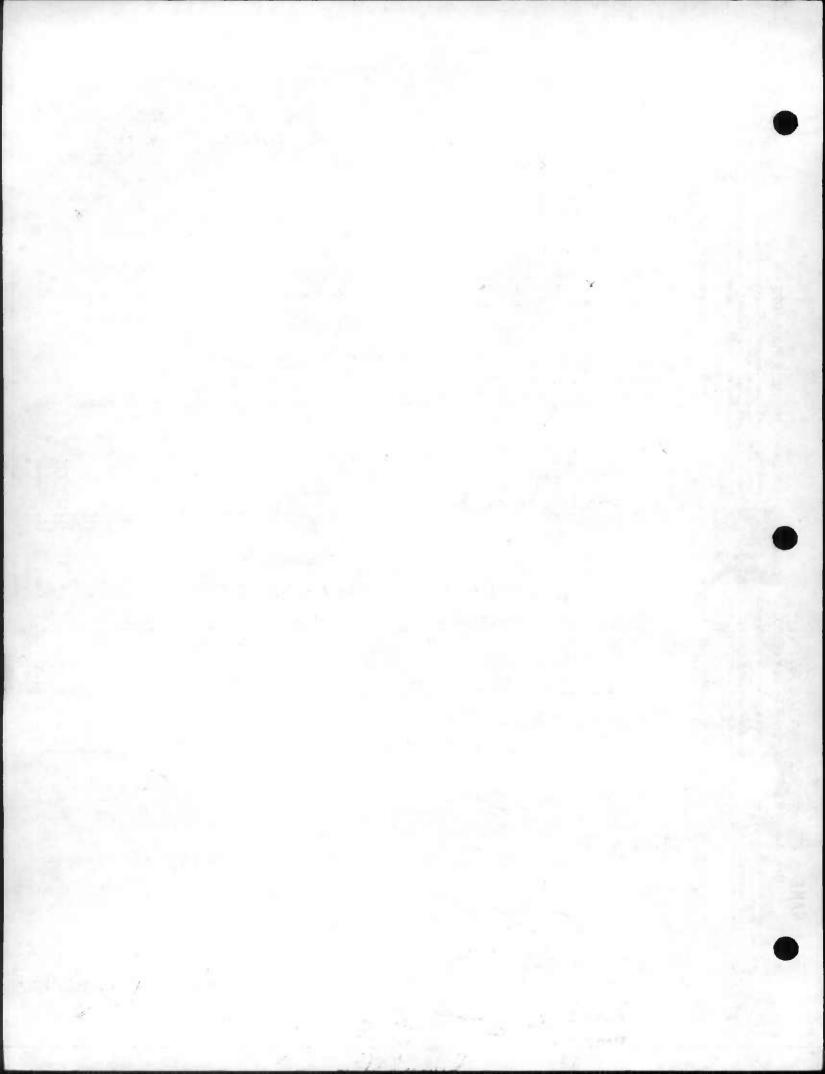
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Matthew John Toomey 0457 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b City, Jown, or Location of Death 4c. Coupty of Peath Examiner LIMORE AINT AGNES HOSPITAL H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 07-17-1914 If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 85 Yes Balto., Director 218-01-6975 Usual Rasidence of Decedant the Maryland 10a. State 10d. Inside City Limits I ahow 10b. County 10c. City, Town or Location rait, or items 23a or 28a-f ahor Examiner must be notified at 1 Yes 2 No Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with "natural", or items 23s or 1102 West Hamburg Street 21230 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation 8 Truck Driver 7 la marked other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be . Pages 1 and 2 should be fil ment of Heelth end Mental H lant: If Item 27 la marked off lury or other traumatic even Lawrence Toomey Mary Sewell 0 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Donald Toomey (Son) 1111 West Hamburg Street Balto Md 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from Stata permit. Page Department of Important: If any Injury or page. Glen Haven Cemetery 2/24/00 Anne Arundel Co., Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Sarvice License 22. Nama and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21227 Approximate triterval Between Onset and Death **Physician** /Medical tmmediate Ceuse (Final diseasa or condition rasulting in daath) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enlar Undarlying Cause (Disaese or injury that initiated avents rasulting in death) Last Due to (or as a consequence of): 16TASTATTC Physician/Medical for usa Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed BACTEREMIA The law 2 No 1 Yes 2 No Attending Physician: funeral director, 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 00 27. Mennar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident after deeth Director: 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 6 within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MP 2/229 900 ALEXANDER Ansow CATON AILE. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB25 Registrar

DHMH 16 Rev 6/95

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				State of M	larylan		artmen rtificate			nd M		giene 🛭 🗍 Reg. No.	0	6165	
	Physicia /Medic	_	1. Decedent's Name (First, Middle, La. ROSE	SI) TAY	lor						2. Dete of Dea Month	4 21	Year 2000	3. Time of Death  12 pm	
	Examino Funeral Director	er	5. Social Security Number 6. S	ns Nursi	ing E	Home  last birthday)  Yrs.	If Under Months		Balt If Under 2 Hours	imo	8. Date of Birti (Month, Day	NI r, Year)	ace (State or Foreign		
١			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									-07		SC 10d. Inside City Limits	
uth with the Marylen 23a or 28a-f show ust be notified at	Director	MD NA  10e. Street and Number		Ва	altim	ore 10f. Zip	Code				1√2 Yes 2 □ No try?				
020 urs efter des			3815 Callaway  11. Marital Status  1 Never Merried 2 Married 3 Widowed *XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	12. Was Decedent Armed Forces	2. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Sive 1 □ Yes 2 □ No				lispanic Orig	gin? (Spe , Puerto I	city Yes or No- Rican, etc.)	14. Rac Ble	USA  14. Race - Americen Indian, Bleck, White, etc.  Specify: Black		
21215-0	within then the Mon	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 3 rd. Grade  16a. Decedent's Usual Occupation (Give kind of work done during most of will be described)  If the DO NOT use retired)  Domestic								ng		6b. Kind of Business/Industry  Various trades		
Maryland 2	should be filed nd Mental Hygin marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Frank Ow	owens 18. Mother's Dora								Maiden Sumar nson			
Baltimore, Man	Pages 1 and 2 sheen of Health end it: If item 27 is my y or other traum		19a. Informant's Name/Reletionship ( Shirley St  20a. Method of Disposition  1 □ Bunial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	okes	C	381 Place of Dispremetery, cre	5 Cal	llav	way A	ven	ue Bal	20c. Location	e, Ma - City or To	ryland	
Balti	permit. Pa Departmen Important: any Injury once.		21. Signeture of Funeral Service Licensee  22. Name and Address of Facility Baltimore, Maryland  WM.C.March FH 1101 E. North Aver  23a. Part. Enter the dispara, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, in the complete of the complet										nue 21202		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)									Dise	ae	Approximate Interval Between Onset and Death	
x 68760,	icate be physicial the bur	/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. <u>Co</u>	Due to (o	r as a consecutive r as a consecutive r	quence of):	la	enti	Hec 19	(den	nt		2 4R8 ,	
s, P.O. Box	5 80	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.								23b. Did tobacco use contribute to the ca			~	
of Vital Records	e law requires hes been sign ge 2 should be	Completed b										en autopsy med?	av:	ere autopsy findings ailable prior to mpletion of ceuse death?	
Vital B	stan: ector	Be	25. Was cese referred to medical examiner?	Hospital:				Ott			1 Check only o	one)		Yes 2 No	
Division of	or Attending Physite death.  Director: After this in by the funeral di	Certification: To	1   Yes   No  27. Manner of Deeth 1   Naturel   5   Pending   2   Accident   3   Sulcide   4   Homicide   Homicide	28a. Date of Inj (Month, Date of Inj	ury ay Year)	28b. Time of Injury	of 2	8c. Injui Woi 1 □	4/LXXVIII	No	28d. Describe I		rred	v) of Route Number,	
_	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edicai Ce	29e. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis of end manner s	ot examine	wledge, deat tion end/or in	h occurred evestigetion	et the ti	me, date and opinion, deet	d place, a	and due to the ed et the time,	ceuse(s) end m dete and place	anner as s	tated. the ceuse(s)	
	To the within To the Comp	Me	29b. Signature and title of certifier	und			290	. Licens	se number $306$	41		Fehn	ed (Month,	Day, Year) 2 2000	
	5 Stat	e	30. Name and address of person who SUTC SOF  31. Date-filed Aforato, Pay, Year)	completed cause of 2   32. Regist	N - 8	Eula	Print)	21	B	alt	my	e mo	21	201	

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#26,28a perPhyG780 2/25/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Feb 14, 2000 2:15 pm James Van Tassel /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8212 Peach Orchard Rd Dundalk Baltimore 8. Date of Birth (Month, Day, Year) Tilly 12,1934 9. Birthplace (State or Foreign Country) PA. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Hours Days Months 1MM 20 F 215-30-5397 65 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Md Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 8212 Peach Orchard Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 No. 11 Yes, Give 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 No Specify. Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 yrs. Balto. Co. Police Der Police Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Buelah Russell James Harlow Van Tassel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 8212 Peach Orchard Rd Dundalk, Md. 21222 Patricia Van Tassel Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 SQ Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Feb 18, Parkwood 22. Name and Address of Facility 2000 Parkville Connelly Funeral Home of DundALK, P.A. Md. 21222 7110 Sollers Point Rd. Dundalk, Inter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Immediate Cause (Final Anne V diseasa or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions Physician/Medical Be Completed by

Division of Vital Records, P.O. B Certification: To

**Funeral** 

Director

28a-f

"natural", or itsms 23s or

or other traun

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**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

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cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last	C Dua to (or as a consequence of)						
Pert II. Other algolificant conditions or	ontributing to death but not resulting in the underlying	cause given in Pert I.	23b. Did tobacco usa co 1 ☐ Yaa 2 🗷 No	ntribute to the cause of death?  3 Probably 4 Unknown			
			24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of causa of deeth?  1  Yes 2 No			
25. Was case referred to medical		26. Place of Deal	th (Check only one)				
examiner? 1 ☐ Yas 2 ☑ No	Hospital: 1 ☐ Inpatiant —2510 utpatient 3 ☐ D	OA Other: 4 Nursing Ho	ome 5 Residence 6 Oth	ner (Specify)			
27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 5 No	28d. Dascribe how injury occur	7ed			
3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

Certifying Physictan: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner steted.

29c. License number

29d. Dete signed (Month, Day, Year)

7505 OSIENDA TOWSON

State Registrar

edical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

O Daw med

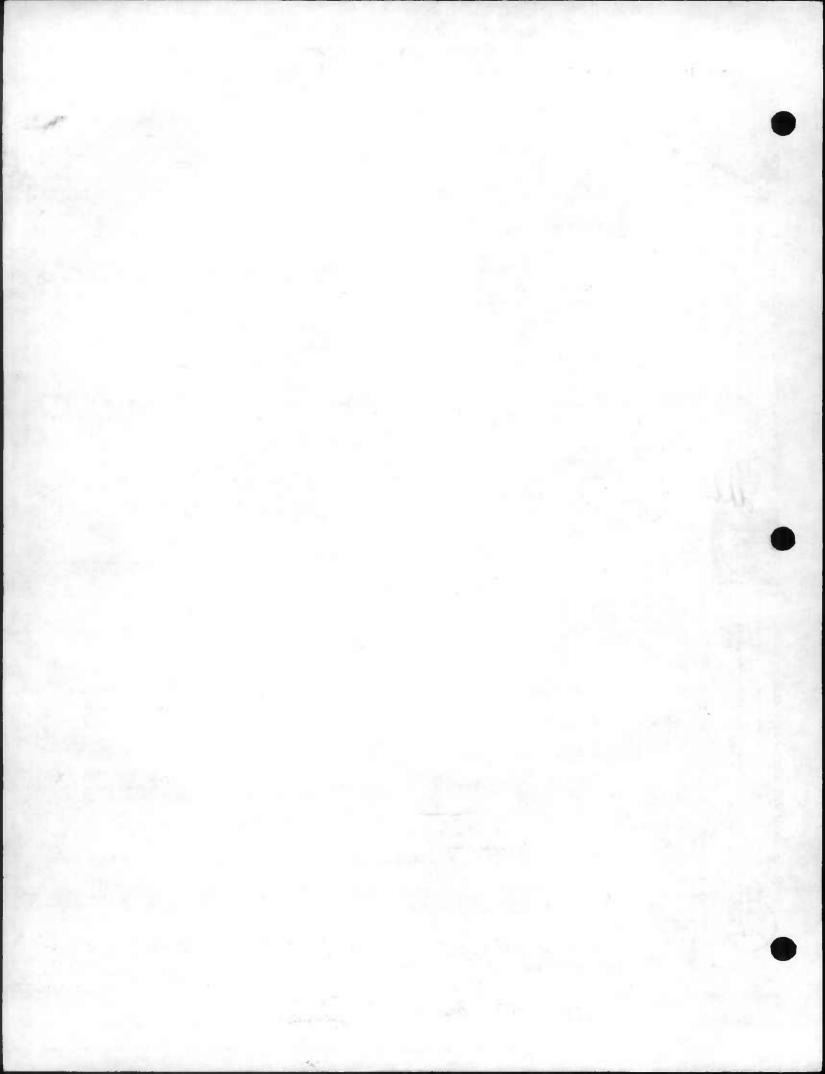
A Mms

32. Registrar's Signeture

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

MORRIS

25



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Dev Month Yeer WOMACK February 22 2000 11:05am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 2910 BELMONT AVENUE BALTIMORE If Under 1 Yaer | If Under 24 Hrs. 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Months 1 ☐ M 2 🗆 🗶 Yrs. 76 Jan 25, 1924 NORTH CAROLINA 118-20-8901 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits TXXYes 2 No BALTIMORE CITY MARYLAND N/A 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2910 BELMONT AVENUE 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 12. Wes Decedent Evar in U,S. Armed Forcas? Black, Whita, atc. 1 ☐ Yas XX No If Yas, Giva 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ Xlo Specify: Specify: BLACK XIX Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) HEALTH NURSING ASSISTANT 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) SHED WILSON MAUDE WILSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Sellars/Daughter 2910 Belmont Avenue, Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Neme of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Suriel 2 ☐ Cremetion 3 ☐ Ramoval from State 2-29-00 CARROLL CO, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARDEN ETERNAL HOPE 22. Nama and Addrass of Fscility 21. Signeture of Funeral Service Ligar WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Batween Onset and Death Immediate Causa (Finel 0 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or es e consequance ot): Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23h. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 24b. Ware autopsy tindings available prior to completion of cause of death? 1 Yes 1 Yes 2 No 25. Was casa ratarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa idence 6 Other (Specify) 1 Yas oma 5 didence 6 Other ( 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

ms 23s or 28s-f show

"natural", or items

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked ofth any Injury or other traumatic event other.

The Medical

Directo

Funeral

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Completed

Be 2

the Maryland

death

hours after

72

21215-0020

Baltimore, Maryland

Physician/Medical a signed by the a þ Completed Be Certification: To # Attor

Box 68760 P.O. Records, of Vital Division 24 hours after deal s Funeral Director

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State Registrar

edical

Nama and ad-31. Data filed (Month, Day, Year) FEB25

5 Pending

investigation

6 ☐ Could not be

27. Menner of Death

1 Detural

2 Accident

3 Suicide

29a. Certifie

4 Homicida

(Check only one)

29b. Signature and title of certifian

28a. Data of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Certifying Phyalclan: To tha best of my knowledga, daath occurred at tha tima, data end place, end due to tha cause(s) and mannar as stated.

1 Yas 2 No

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

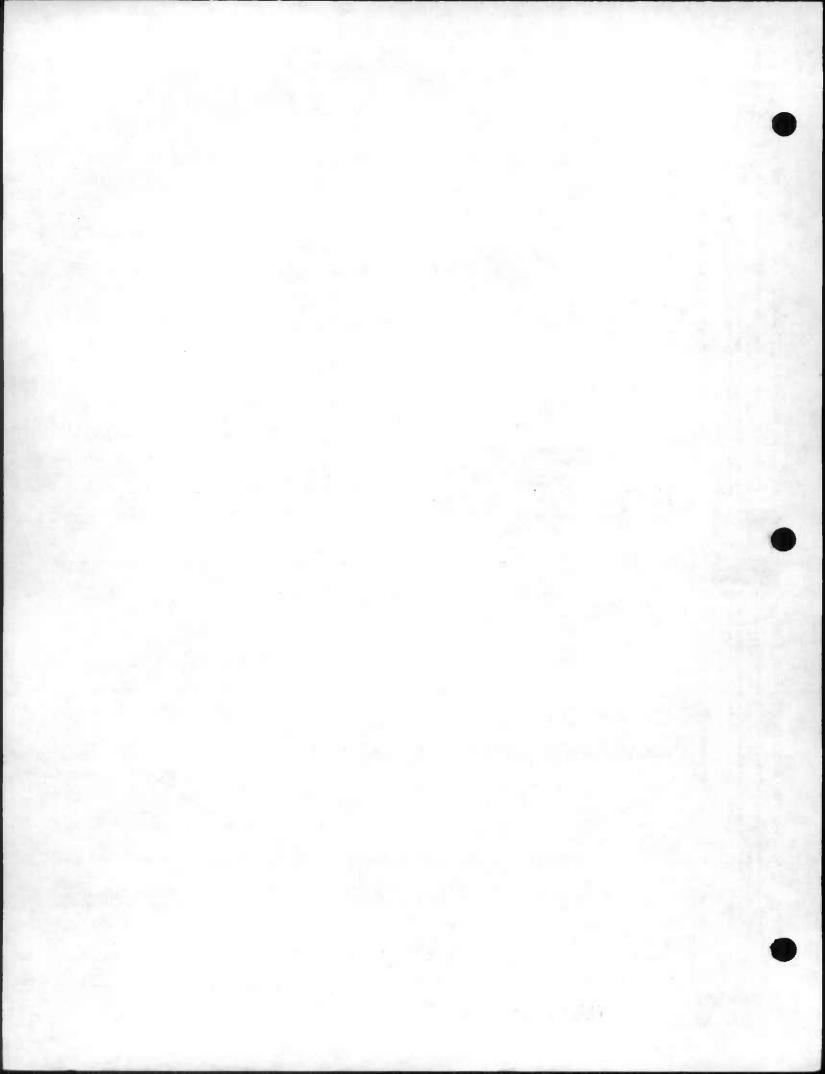
cause of death (If m 23e) (Type: Frint)

> 32 Registrar's Signature 2000

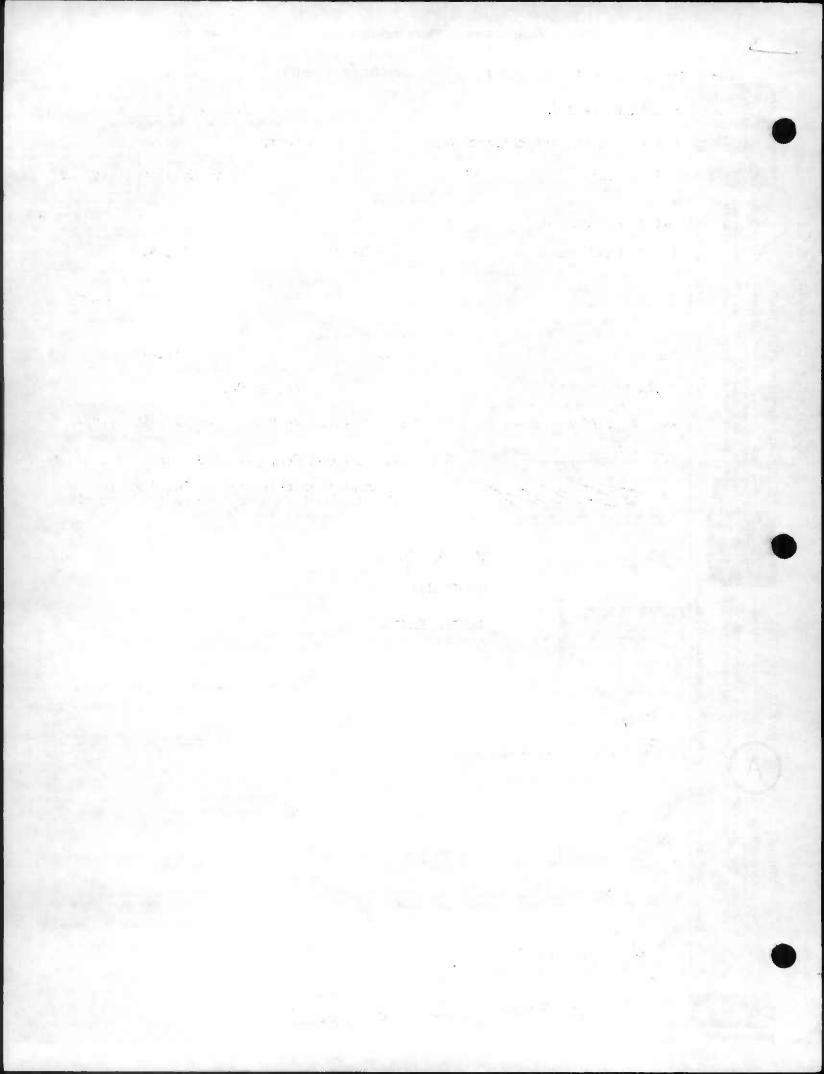
**DHMH 16 Rev 6/95** 

28b. Time of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)



*		Please Type or Print In Black Indelible Ink. Assur State of Maryland / Department of Health a			06168
	Amended	d Item#23a perPhyG780 2/25/2000 EW Certificate of Death	F	Reg. No.	
		Decedent's Neme (First, Middle, Last)	2. Dete of Dee	Dey	3. Tima of Deeth
	hysician Medical	FREDERICK WALTERS	FEBRUARY	-	000 7:150
4	xaminer	4e Fecility Neme (If not institution, give street end number)  4b. City, Tow	vn, or Location of Deeth	4c. County of	of Death
		Lorien - Riverside Nursing Home Belca	mp	HARF	ORT
Fu	neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 2 Months Deys Hours	4 Hrs. 8. Dete of Birth Min. (Month, De)		Birthplece (Stete or Foreign Country)
	ector	220-24-8121 12M 2 F 69 Yrs.	March 1	3, 1930	Maryland
p.		Usual Residence of Decedent			40d Include Olt - Limite
aryta	1	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
N N	cto	Maryland Harford Bel Air			
ë s	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	het Country?
5-0020 72 hours efter death with the Meryland	(a) (a)	306 J. Canterbury Road 21014		u.s.A.	
ep J	by Funeral	11. Maritel Status  12. Wes Decedent Ever in U.S. Armed Forces?  13. Wes Decedent of Hispenic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- , Puerto Rican, etc.)	14. Rece Bleck	- American Indian, k, White, etc.
20 sefte	E V	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify:	White
215-0020 thin 72 hours efter dea		3 Widowed 4 Divorced Year or Detes: 1951 – 59			
	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	of working	16b. Kind of Bus	siness/Industry
212 d withir	A G	Elementery/Secondery (0-12) College (1-4or 5+) Welder		Electr	inal
d 2121 filed within Hygiene.	A O		r's Name (First, Middle,		
	other traumatic event, the Magical		thy Cecil		
larylan	To	19e. Informent's Name/Reletionship (Type, Print)  19b. Meiling Address (Street end Number		City or Town	State 7 in Code)
200	then	Mary M. Walters (Wife) 306 J. Canterbury			
e de	other tr	20b. Method of Disposition  20b. Plece of Disposition (Name of cemetery, cremetory or other piece)	Date Date		City or Town, Stete
		1 M Burial 2 Uremetion 3 Uremovel from State			
ting.	duy.	4 □ Donetion 5 □ Other (Specify) Baltimore National Cem		bactum	ore, Maryland
Baltimore	any Injury	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funer 610 W. MacPhail	al Home of Road, Be	Bel Air l Air, M	, Inc. D 21014
		23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart feilure. List only one cause on each line.	cerdiec or respiretory er	rest,	Approximete Intervel Between
Physi					Onset end Deeth
/Me	dical	Immediate Cause (Final disease or condition Reveal for the condition Re			~ luen
LXaii		resulting in deeth)  Due to (or es e consequence of):			0
D	sit	HYPERTENSION			
, P.O. Box 68760, that the death certificate be executed	inel-transit Examiner	Sequentially list conditions, if eny, leeding to immediate			
60,	- 5	Cause (Disease of Files			
6876	Physician/Medical	thet initiated events resulting In death) Lest Due to (or es e consequence of):			
X 6	200	d			
Box auth cent	for use es				
O. 8	deteched for use	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did 1	tobacco use con	tribute to the cause of death?
Tat ta	detec	Huga temain	1 🗆 '	Yes 2 No	3 Probably Unknow
	2 6		04- 14/		24b. Were eutopsy findings
-	Completed	Dialetes Kellite		en eutopsy med?	eveileble prior to completion of cause
@ A	du				of death?
E 12.	a CO		101	res 2000	1 ☐ Yes 2 ☐ No
#	Be do	25. Wes cese referred to medicel 26. Place	of Deeth (Check only of	ne)	
Physical Phy	7 A	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 42 Nu	rsing Home 5 Resid	dence 6 Othe	er (Specify)
		27. Menner of Death 28e. Dete of Injury 28b. Time of Injury 28c. Injury et Work? 28c. Injury et Work?		now injury occurr	ed
Division or Attending offer death.	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be			
Division of Attended of the deat	TI DY	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tov	Street end Numbe vn, Stete)	er or Rurel Route Number,
To the Hospital or within 24 hours effect.	completely filled in by the fune Medical Certification				
To the Hospital within 24 hours	pletely fill	29e. Certifier (Check only (Check only a Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deef	d plece, end due to the	ceuse(s) end me date and plece, e	nner es steted. and due to the cause(s)
the H	led be				
P × F	Com	29b. Signeture and title of certifier  29c. License number	( 0		(Month, Dey, Year)
		Clauche A- Krohn MD D500	40	02,18	3,2000
		30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)	NA		
		1308 Business letr Way #102; Edgewood	ND 210	740	
	State	31. Dete filed (Month, Dey, Year) 32. Registrings Signature			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death Month **Physician** Charles Morgan Woody, Sr. 28, January 2000 18:29 /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) March I, 1931 7. Age (In yrs. last birthday) 5. Sociel Security Number 9. Birthplece (State or Foreign Months Days 10XM 2□ F Hours Min. West Virginia 68 Yrs. 236-44-8843 Usuel Residance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2X No Director Baltimore Parkton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1756 Parsonage Road 21120 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Amped Forcas? 1 ⊠ Yas 2 □ No It Yas, Giva 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarlcan Indian, Black, Whita, atc. 1 Navar Merried 2 Married White 1 ☐ Yas 2X No Specify: Specify: à tt Yas, Giva Yaar or Datas: Korea 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highest grade completed) Social Security Elamantary/Secondary (0-12) Collaga (1-4or 5+) Claims Adjuster Administration 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) BB H. Ray Woody Margaret F. Hooten 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mildred Rita Woody/Wife 1756 Parsonage Rd., Parkton, MD 21120 20b. Placa of Disposition (Name of camatary, crametory or other place) Feb. 2, 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Middletown Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Freeland, MD 2000 21. Signatura of Funaral Sarvice Licansee 22. Nama end Addrass of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one change in the disease. 17349 Approximete Intarval Batween Onset and Deeth immediata Ceuse (Final Cardiac arrest disaasa or condition rasulting in daath)

**Physician** /Medical Examiner

any inj

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

death

hours after

Hygiene.

out and Martal b

yes 1 and 2 about be centiment of Health and Marti-vortant: If hem 27 is righty or off

permit.

Woody, Charles

Maryland 21215-0020

Baltimore.

Box 68760

P.O.

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24 To the To the I

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Examiner Physician/Medical ed by the e been signed by t should be detect g Completed page 2 hes Be 2 Certification:

Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in death) Last

Dua to (or as a consequenca of):

Massive hemorrhage

Dua to (or as e consaquanca of):

LEFT RENAL HEMORRHAGE

Dua to (or as a consequance of):

Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of cause of deeth?

1-2 hours

1X Yas 2□ No

1 □ Yas 2 No

25. Was casa rafarred to medical 1 Yes 2 No

5 Panding Invastigation

6 Could not be detarmined

28a. Data of Injury (Month, Day Year)

Hospital: 1₺ Inpatiant 2□ER/Outpatient 3□ DOA 28b. Tima of

28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify)

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Homa 5 Residenca 6 Other (Specify) 28d. Dascribe how Injury occurred

Greater Baltimore Medical Center

26. Place of Death (Check only ona)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a, Cartifian (Check only one)

27. Mannar of Death

1 Natural

2 Accidant

4 Homicide

3 Suicida

1 🖄 Certifying Physician: To tha best of my knowladga, daeth occurred at tha tima, data and placa, and dua to the ceuse(s) and manner es steted. 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signatura and titla of certifier 46

29c Licansa number D43003

29d. Deta signed (Month, Day, Year)

1/29/2000

State Registrar

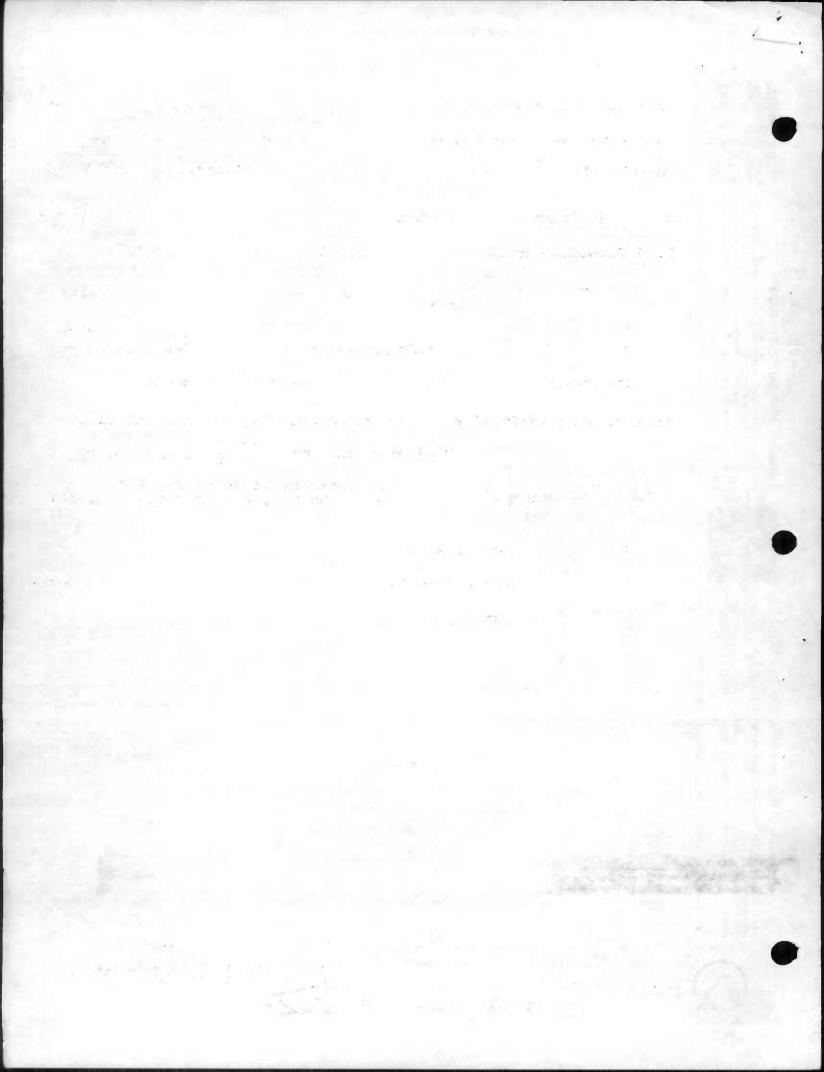
edicai

Nathan A. Dunsmore, M.D. 31. Date filed (Month, Day, Year)

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

6701 N. Charles Street, Baltimore, MD 21204

200 Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year JAMES S. WILSON. JR. February 21, 2000 10:25 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 312 Sunray Court
5. Social Security Number 6. S Abingdon
If Under 24 Hrs. Harford 8. Dete of Birth (Month, Day, Year) DCC. 24, 1962 Birthplece (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 □ F Yrs. Maryland 212-78-1207 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harkord Abingdon 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 312 Sunray Court 21009 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indien, 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Crane Operator Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James S. Wilson, Sr. Catherine L. Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Wilson (Wife) 312 Sunray Court. Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens! 2/24/00 Bel Air, Maryland 22. Name and Address of Fecility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD 210 21. Signature of Fungral Service Licenses 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Batween Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Branchiolitis delitorans organiting preumonia Due to (or as a consequence of): Chroniz esophaged Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Dyrn of ITy d dis orde Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 2000 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? 1 Natural 2 Accident 5 Pending 1 Tyes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner physician s the buriel Box 68760. P.O. signed to Records, Division of Vital or Attending Physicien: the state deeth.

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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**Physician** 

/Medical

Examiner

Physician/Medical

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Certification: To

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filed within 72 hours efter

21215-0020

Baltimore, Maryland

24 hours efter deeth Funeral Director: A pletely filled in by the f Hospital edical completely within 2 5

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year) 25

29a. Certifier

(Check only one)

29b. Signature and title of certifie

erson who completed cause of death (Item 23a) (Type, Print) 300 4 Emmorter Rd. Altingdon MD 21009 32. Registrar's, Signature ooks

Feffrey Schluederbeg MD

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

036951

29d. Dete signed (Month, Day, Year)

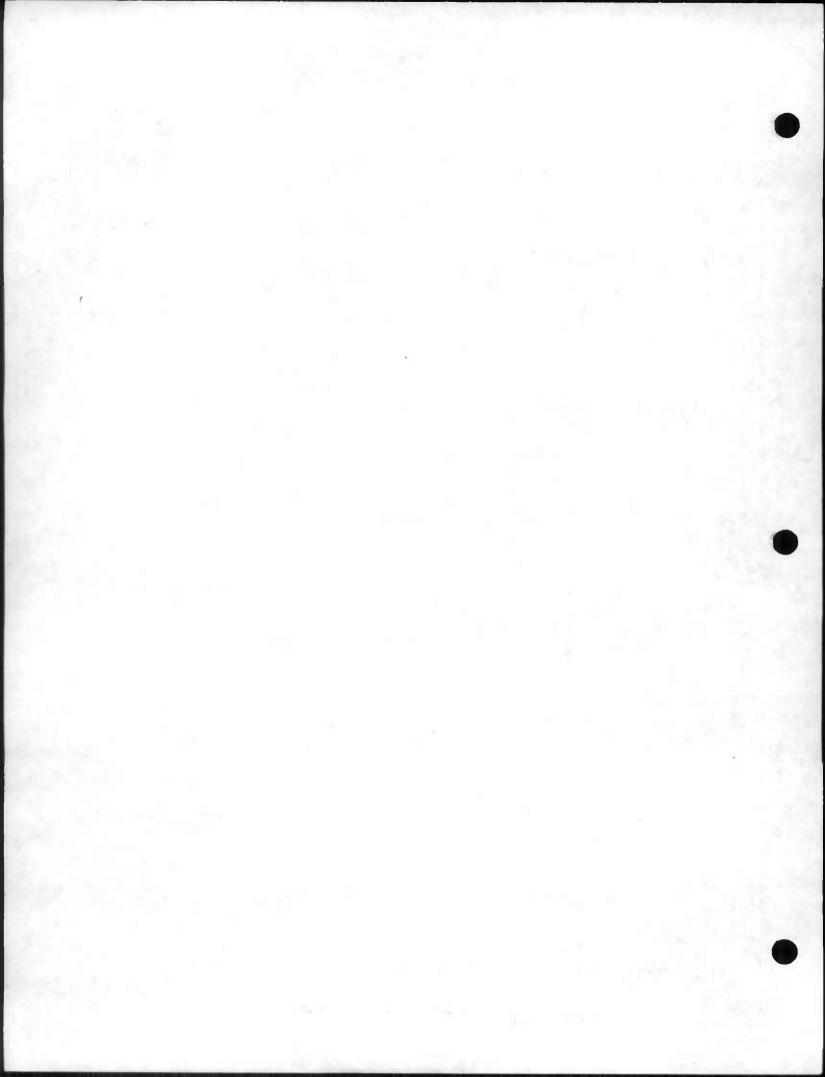
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State of Maryland / Department of Health and Mental Hygiene

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				Certifica	ile oi	Deam		R	eg. No.			
	1. Decedent's Nama (First, Middle, Las	st)						2. Date of Dea Month	th Day	Year	3. Time of Death	
Physician /Medical	Leon Wo	710c						February		2000	7:10 A	
Examiner	4a Facility Name (If not institution, give 3328 CLARKS LAN					BALT	wn, or Loc IMORE	ation of Death	4c. County	of Death	N/A	
Funeral Director	5. Social Security Number 217–30–7379 6. S	ex 7. Age	(In yrs. last birt	hday) If Und Month	er 1 Year S Days	If Under a	Min.	8. Date of Birth (Month, Day PR • 17	Year) 1932	9. Birthp Coun	lace (State or Fore try) MD	
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										0d. Inside City Lim	
or 28a-f show be notified at Director	MD				1 <b>X</b> Yes 2□							
0 8 0	10e. Street and Number 3328 CLARKS LAN	E #E		10f. 2	ip Code	2121	5		0g. Citizen of V	What Coun	U.S.A.	
St. or Hems Examiner in by Funer	11. Merital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates:		If Yes, sp	ecity Cub	Hispanic Original, Mexican Specify:	gin? (Spec n, Puerto P	cify Yas or No- lican, etc.)		e - Americ ck, White, o		
Scal	15. Decedent's Ed (Specify only highast gra	lucation de completed)	t of workin	a	16b. Kind of Bu	usiness/Inc	lustry					
ygiene. Ner than "natur It, the Medical Completed	Elementery/Secondary (0-12)		College (1-4or 5+)						GENITOD	CITA III		
Hygik Hygik Sifher ent, th	17. Father's Name (First, Middle, Last)		150	CIAL W	JKK A				SENIOR Maiden Suman		ER	
Mental H riked off rife ever To Be	ISRAEL			WOOLE	7	IDA					SACHS	
27 to mar r traumet	19a. Informant's Name/Relationship (I								RE, MD			
off: If Nem	20a. Method of Disposition  1 Bunal 2 Cremation 3 X  4 Donation 5 Other (Specify		cemeter	Disposition (A y, crematory of HA CHA	r other pla	ice)	2/	Date /24/00	20c. Location - BET SHE		wn, State  ISRAEL	
Departm Imports any Inju	21. Signature of Funaral Sarvice Licen	Cittle				ess of Facilit	SOL	LEVINSO	ON & BRO			
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.										MD 21208 Approximate Interval Between	
ing physician and se as the burlal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Seg	bue to (or as a c	consequence o	f):					1		
for use a												
ed by the attend detached for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 4				
b ed	Renal Insu Congestive	fficiency		Hype	enten	รเทา				1		
2 shoul	Congestive	Heart Fa	ilore					24a. Was a	med?	av	ere autopsy findin ailable prior to mpletion of cause death?	
page 2	anemia							1 🗆 Y	es 2 No	10	Yes 2□ No	
s certificate director, pag To Be Co	25. Was case referred to medical examiner?				100		e of Deeth	(Check only o	ne)			
T di	1 Yas 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatier 28a. Date of Injury (Month, Day		ime of	28c. Inju	ork?	2		ance 6 Oth		(y)	
free death free ctor: in by the rtificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 ☐ Yes 2 ☐ No  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rure! Route City or Town, State)			
	4 ☐ Homicide building, etc. (Specify)  City or Town, State)  29a. Certifier 15A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.											
Funeral Di Funeral Di letely filled in dical Cer		niner: On the basis of										
within 24 hours after to the Funeral Dir. Completely filled in Medical Cert	(Check only 2 Medical Exam	niner: On the basis of				se number			29d. Data signe	ed (Month,		
within 24 hours aft To the Funeral Di completely filled in Medical Cer	(Check only 2 Medical Examone)	niner: On the basis of and manner state	ted.	4	29c. Licen	se number	088		29d. Data signa Februo		Day, Year)	



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06172

Certificate of Death

Reg. No.

			Certifica	ate of	Death		Reg. No.		0 ; 1 6.		
100	1. Decedent's Name (First, Middle, La	ist)				2. Date of De		Vess	3. Time of Death		
Physician	MARY L YATES	FEBRUA	RY 21,	Year	5:20pm						
/Medical Examiner	4a Facility Name (If not institution, give	re street end number)		-	b. City, Town, or	Location of Deet	-				
Funeral		Sex 7. Age (In yrs	. last birthday) If Un Mont	der 1 Year	LEN BUI	8. Date of Bir	ANNE	9. Birthpla Countr	ace (State or Foreig		
Director	Usual Residence of Decedent	74				(7-1-23	-2.3	SUMF I	rer, s.c		
the Maryland 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location										
vith the Ma or 28a-f s be notified Director	10e Street and Number		101	Zin Codo			10g. Citizen of W	Pant County	n/2		
burs after death with all, or items 23s or Essentrat must be but but by Funeral Dit	10e. Street end Number 38 BROOKS TER	RACE		Zip Code 21.06			U.S		ry r		
	11. Marital Stetus  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces?  1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:		cedent of Hispecify Cube		Specify Yes or No to Rican, etc.)	Specify	a - American k, White, et BL	tc.		
s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural; other treumatic event, the Medical Ex-	15. Decedent's E (Specify only highest gro	ducation ede completed)	16a. Decedent's U	sual Occup	ation during most of wo	orking	16b. Kind of Bu	siness/Indu	ustry		
within ene.	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired	1)		To	22 01			
should be filed withir ad Mental Hygiene. marked other than imatic event, the M To Be Compi	1.0		CASE	ITER					ERVICE		
d oth even	17. Father's Name (First, Middle, Last	)			18. Mother's Na	me (First, Middle,	Maiden Sumem	9)			
Mental Mental arked of attreventor	ALLEN HARGROV	E			BERTH	A MCPHE	RSON				
2 should and Men is marks sumatic	19a. Informant's Neme/Reletionship		19b. Meiling Addr	ess (Street	-			Stete, Zip (	Code)		
d22 thar thar treu	BEVERLY YATES,	DAHGHTED	38 BROO	IZC M	FDDAGE	CT EN	DIIDNITE	MD	21060		
Health Health em 27 Wher tr	20a. Method of Disposition		Plece of Disposition (		EKKACE	Date	20c. Location -				
Page nent o ant: If ury or	1X Burial 2 Cremation 3 C	2-26-00			, 5.0.0						
permit. Pa Departmen Important any Injury pace.	21. Signature of Funeral Service Lice	nseen All ()	HOWE	LL F	ss of Facility UNERAL	HOME					
	23a. Part1. Enter the disease for con shock, or heart failure. List only	plications that caused the	ith. Do not enter the n	node of dyir	ng, such as cardia	GHTS AV	rrest,		1D 21207 Approximate		
Physician	snock, or near failure. List only	one ceuse on each line.							Interval Between Onset and Death		
/Medical	Immediate Ceuse (Final	1,11	10 60 10	000					1-2 mo		
Examiner	diaeasa or condition resulting in death)	a	rg Can	cer					1-6100		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Due to (	or e e consequence	of):							
in si		b									
executed in and ial-transit Examiner	Sequentially list conditions, if any, leeding to immediate	Due to (									
ndificate be executed ing physician and a sa the bunial-transit Medical Examir	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
certificate be executiving physician and use as the bunial-tran	resulting In deeth) Lest	d									
at the death ce d by the attend letached for us Physician/	D . V On	cant conditions contributing to death but not resulting in the underlying cause given in Part I.									
ysi	Part II. Other significant conditions of	contributing to death but not re	sulting in the underlylr	ng ceuse giv	en in Part I.			1	the cause of death		
= 00								1 Yes 2 No 30 Probably 4			
v requirements					22-1	24a. Was	an autopsy ormed?	avei	re autopsy findings ilable prior to apletion of ceuse eath?		
ysicien: The lav is certificate hes director, page 2 To Be Comp						1 🗆	Yes 22 No	10	Yes 2 No		
o Por P	25. Was cese referred to medical			_	00 Di/ Di		/ \				
icle rectraction	examiner?	Hospital:		DOA OIL	or.	eth (Check only					
7 50 7	1 Yes 2X No	1 ☐ Inpatient 2 L		28c. Injur	4 LI Nursing		dence 6 Other		)		
Attending F or death. ector: After by the funer iffication:	Natural 5 Pending investigation		28b. Time of Injury	26d. Describe	now injury occurr	ed					
Part of	3 Suicide 6 Could not be determined	28e. Plece of Injury - At I building, etc. (Spec	28f. Location ( City or To	Street and Numb wn, Stete)	er or Rurel	Route Number,					
To the Hospital within 24 hours: To the Funeral completely filled	29e. Certifier Check only one)  Check only 2 Medical Exercises	nysician: To the best of my kn miner: On the basis of examin end menner atated.	owledge, death occurr ation and/or investigat	red at the tir tion, In my o	ne, dete and place pinion, death occ	e, end due to the curred at the time,	ceuse(s) end me date end piece,	nner es sta and due to	ated. the cause(s)		
Me Me	29b. Signature end title of certifier			29c. Licens	e number		29d. Date signer	1 (Month, E	Dey, Year)		
F ≱ F 8	IMMA	(ALLAND IN		0	UUMIL		7/2	11/1			
	0000017	VICEVIVO		<b>V</b> )	74809		40	7/10			
	30. Name and address of person who	completed cause of death (tte	om 23e) (Type, Print)			0		, , -			
	Kaiser Permo	mente &	028 Rite	chie	1+GING	ras a	dena.	MI	) 21122		
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	nature		1						
Registrar	EED 2.5 2000	Beneva L	9. Anni	11		- T					



#### Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** ONGSMA OLLIE 3:45 AM FIZIB 12 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Lorien Nursing Home Columbia Howard 5. Social Security Number 6 Sex if Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 DF Devs Hours 215-20-6684 72 Yrs. Director Sept 22, 1927 PA Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Modical Examiner must be notified at the Marylet MD. Howard Columbia 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6334 Cedar Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after be a pearment of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural" or hanny Injury or other traument. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thelma Logsdon James Cook 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charles Heron, Social worker 7121 Columbia Gateway Drive, Columbia, Md. 21046 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. Baltimore/Washington Crem. 2/25/00 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a specific provided by the control of the con Approximate Interval Between Onsel and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medicai Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue buriel-tran Due to (or as a consequenca of): that the death certificete be exec physician Physician/Medical the Due to (or as a consequenca of): USB 85 ettending Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by the Schoolic CardioVasular 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? peen page 2 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending investigation 1 PNatural s after deeth. 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 6 Hospital c 24 hours at Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical To the I

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

State Registrar 29b. Signature and title of certifie

SYED

\* DIE 31. Date filed (Month, Dey, Year) 32. Registrade Signature FEB 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

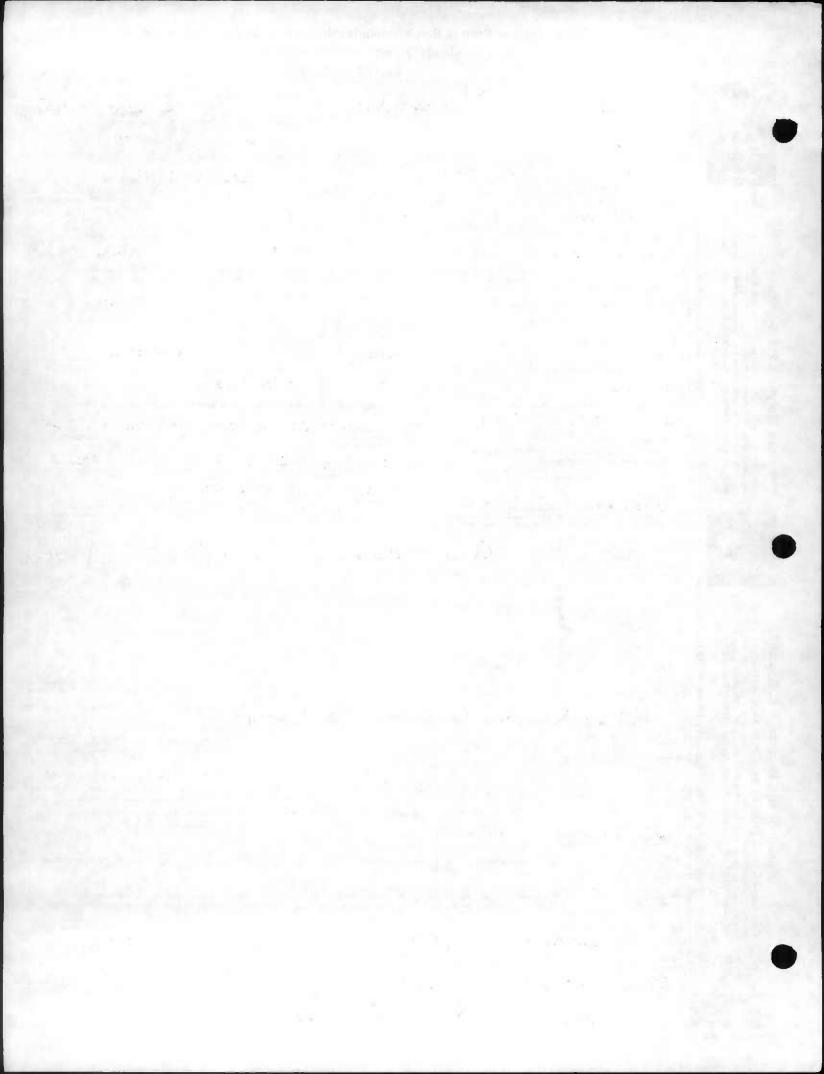


14333 Laurel

29c. License number

29d. Date signed (Month, Day, Yeer)

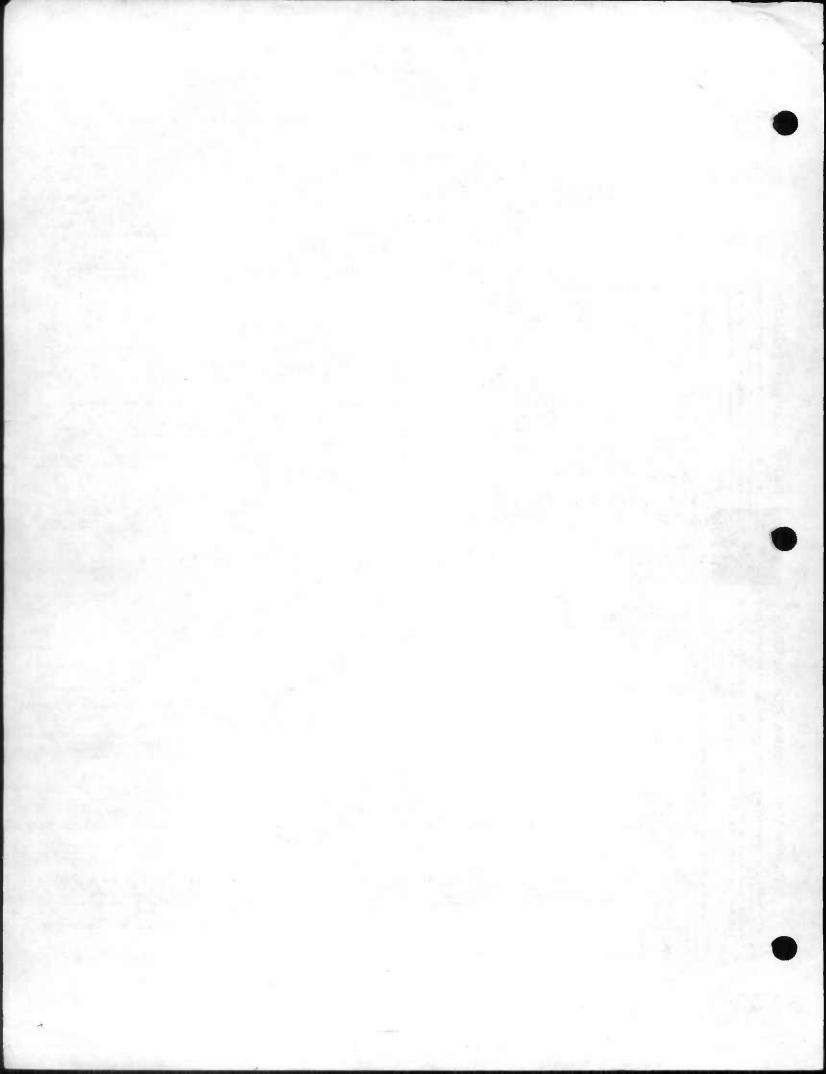
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State of Maryland / Department of Health and Mental Hygiene 0 6 7 4

					Ce	rtificat	e of	Death		Re	ıg. No.			
		1. Decedent's Neme (First, Middle, Last	)						1	2. Date of Death Month	h Day	Year	3. Time of Death	
Physici /Medic		Lisa Marie Zepp								FEBRUAL		2000	1018 AM	
Examin		4a Facility Neme (If not institution, give FRANCIS SCOTT KEY	BRIDGE M	) IARKER	K 4	80		DUND	ALK				3	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 27 Yrs. 27 Yrs. Months Days Hours Min.									Birth Day, Year) 9. Birthplace (State or Country) 27,1972 Mary Tand			
Jend 18		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits	
the Many 28a-f ah nottlied	Director	Maryland N/A		Ba1	timor	10f. Zig	Code			10	og. Citizen of	What Cour	Y Yes 2 No	
23a or		3619 Hickory Aven	ue			10% 24		1211		·	USA			
21215-0020  d within 72 hours after death with the Maryland glene. If then "natural", or hame 28s or 28s-1 show the Maryland at the Wedles Examiner must be notified at the Wedles Examiner must be not the Wedles Exa	by Funeral	11. Marital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Tyes 2 Tyes, Give Year or Dates:	?   No				Hispanic Ori an, Mexicar Specify:		cify Yes or No- Rican, etc.)		ce - Americ ck, White, y: Wh		
72 hc	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dece (Give	dent's Usu	al Occup	pation during mos	t of worki	ng	16b. Kind of B	usiness/Ind	dustry	
within then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done during most of we life. DO NOT use retired)  Accounting						Hardwa	re P	roducts	
D D		1.7. Father's Neme (First, Middle, Last)								(First, Middle, N			Toduces	
should be and Mentel merked or umeric eve	To Be	William Thomas Z	epp, Jr.						Lill	lian W	illiam	S		
Maryland d 2 should be flie th and Mentel Hy 7 la merked othe traumatic event	-	19a. Informant's Name/Reletionship (T)	pe, Print)		19b. Maili	ng Address	s (Street	and Number	er or Rura	Il Route Number,	City or Town	, State, Zip	Code)	
C C N L		Thomas Zepp, Jr.	Father			11en		ve Ha	anove	er, Penn	sylvan	ia 1	7331	
- 0 - 2 0		20a. Method of Disposition  \times \t	temovel from Stete	COI	ce of Disponentery, crea	matory or o	other pla		2/		Elder		own, State , Maryland	
Baltimo pemit. Page Department of important: If eny injury or		21. Signeture of Juneral Service Licens	2 (X/	10)	E	Burge	e-He	nss-S	eitz	Funeral	Home,	Inc.	21211	
		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only or	ications thet cause	ed the death.	Do not en	ter the mod	de of dy	ng, such es	cardiac o	or respiratory arre	Mary	land-	Approximete Intervel Between	
Physician / /Medical / Examiner	ler.	Immediate Cause (Finel disease or condition resulting in death)	Chest.	Tirke Due to (or				mpres	sim	. osphy	yue.	1 1 1 1 1	Onset and Death	
OX 68760, certificate be assouted admin physician and use as the buriel-transit	Tedical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of):												
BOX path certification for use	an/M	MITTER STATE	d.  conditions contributing to death but not resulting in the underlying cause given in Pert I.											
. p . p	Physician/	Pert II. Other aignificant conditions cor								23b. Did tobecco use contribute to the caus				
. E . D	by Phy							911		1 🗆 Ye	10 No	3 Pro	bably 4 Unknown	
	Completed t					H				24a. Wes en perform		av co	ere autopsy findings reliable prior to impletion of cause death?	
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Of VIta Physician: this certific nal director,	Be	25. Wes case referred to medicat axaminer?	lospital:	-			Ot			(Check only on				
	1: To	1)∑Yes 2□ No  27. Manney of Death	1 ∐ Inpat 28a. Dete of Inj	iury 2	R/Outpatie 8b. Time o		28c. Inju	4 LI NI		me 5 ☐ Reside 28d. Deşcribe ho			M SCENE .	
VISION Attending r deeth. Ictor: After	atlor	1 Natural 5 Pending investigation	(Month, D	2QO	830	MA		rk? ]Yes 2.[S		DRIVER				
2 2 4 4 5	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Ir building, e				y, office			28f. Location (St. City or Town	reet and Num , State)	ber or Run	al Route Number, My 180 BAM WORE	
To the Hospital Within 24 hours 4 To the Funeral Completely filled	edical	29a. Cartifier 1 Certifying Physical Check only one)	sician: To the best ner: On the basis of end menner s	of my knowl	edge, deat	h occurred vestigation	at the ti	me, date en opinion, dea	d place, i	and due to the ca	use(s) and m	anner as s	tated.	
To the Ho within 24 i To the Fu completel	Me	29b. Signeture and title of certifier	J. Z manner 3			29		se number		2	9d. Date signe			
		Mayre 0	melbel	C door the second	20) /	Peiest\	0	.C.M.	Ξ.		FEBRU	ARY 2	2, 2000	
()		30. Name and address of person who co	MEW HW				t, B	altim	ore.	Marvlan	d 2120	1		
Sta	te	31. Dete filed (Month, Day, Year) FFR 2. 5. 200		rer's Signetu		10	00 4	//						

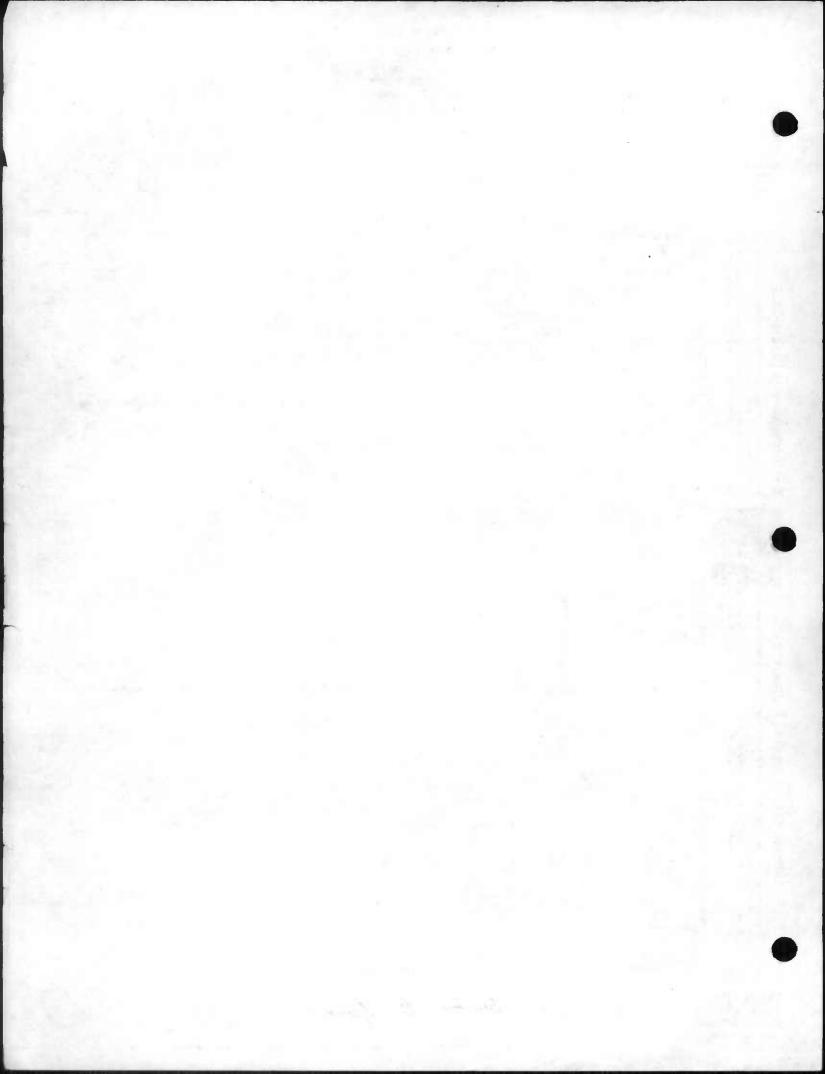


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Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** ANDRESON AUNINA 0:00 Am 00 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIDEK SAPISTURE HUNDER 24 Hrs. 18 D TRNES15 -AK CEMICLE If Under 1 Year 5. Sociel Security Number 6. Sex 7 Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 10 M 204 Hours 212-16-17 32 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 100 Inside City Limits 28a-f ahow the Medical Examiner must be notified at SNOW 1 Yes 2 No Director ORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or to B 2186 3 USA Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, Whita, atc. filed within 72 hours after Hygiene. other than "natural", or he 1 Yes 2 Ne 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 □ Widowed 4 □ Divorced AMERICHN Year or Detes Completed 16a. Decedent's Usual Occupation
(Giva kind of work done during most of working
life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondery (0-12) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglers, Important: if item 27 is marked other that any injury or other traumatic event, that page. omostic 2 And no 17. Father's Name (First, Middle, Last) OR 61 18. Mother's Name (First, Middle, Maiden Sumame Be 10 N 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARKA Well OB alton 20a. Mathod of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 20c 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete REMATION 11000 5 Clother (Specify) 60 21. Signeture of Funerel Service Ligensee 22. Neme end Address of Facility ALES DONCE (R 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deat **Physician** /Medical Immedieta Causa (Final 0 disease or condition resulting in death) **Examiner** Due to (or es a consequence of): Examiner ician and burial-transit 100 that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical 4 Due to (or es a consequence of): USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the s should be detached 1 Yes 2010 3 Probably 4 Unknown Records, ρA 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 DINO 1 □ Yes 2 □ No certificate Division of Vital Attending Physician: director, Be 25. Wes casa raferred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Neturel 5 Pending Investigation n 24 hours after death.

The Funeral Director: After pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide 6 Hospital 1 Restriction Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29c. License numbe 30. Neme and address of person who complated cause of death (Item 23a) (Type, Print) 0 William Robins, M.D., 1104 Healthway Dr., Salisbury, Md. 21804 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 0 1 2000 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death Nitra June Alexander JANUARY 25 2000 11:40 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sacred Heart Hospital 5. Social Security Number 6. Sex Cumberland Allegany. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2QF 78 Yrs. 236-36-2065 Dec. 3, 1921 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 81 Mozelle Street 26726 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Postal Clerk Postal Service 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Keys Ira Washington 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorethea Price (Daughter) Street, Keyser, WV 48 South F 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) Potomac Mem. Gardens 1/29/2000 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Markwood Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest, shock, or heart failure. List only one cause on each line. 26726 Approximate Interval Between Onset and Death Thalamic Hemorrhage Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION-MYOCAROIAL INFARCTION 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? OBSTRUCTIVE ALRWAY DISEASE 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

Examiner physician and s the burial-transit Box 68760, Physician/Medical 980 0 0 P P Division of Vital Records. Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, I Be Certification: To

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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**Funeral** 

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Pages 1 and 2 should be fill ment of Health and Mental H ant: If them 27 is marked off jury or other traumatic even

Department of Important: If any injury or other

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier

Jaum

29¢. License number SARIM R MIR, MD

29d. Date signed (Month, Day, Year) Jan, 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/w

MD 21502 SARIM R. MIR, MO 902 SETON DR. CUMBERLAND

State Registrar

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31. Date filed (Month, Day, Year) JAN 2 8 2000 32. Registrar's Signature

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State Registrar

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Lillian Viola Blank JANUARY 26,2000 2345 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year)
August 17,1906 Maryland Birthplece (State or Foreign Country) Funeral Deys 1□ M 210 F 93 Yrs 218-34-4292 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland Allegany Mt. Savage Wayes 2□No Directo 28a-f 10e Street and Number 10g. Citizen of Whet Country? 10f. Zip Code Berns 23s or 16205 Calla Hill 21545 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baitimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White py 3 K Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 cafeteria worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: If them 27 is marked oth lury or other traumatic even Be Peter Paul Michaels Minnie Margaret Martens 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVale, Maryland 21502 Judy Burford 4 Linda Way 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Patricks Cemetery 29, 2000 Mt. Savage, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Durst Funeral Home P.A. ohu 57 Avenue Frostburg, Maryland21532 Frost 23a Pm1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burlal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): signed by the a Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy findings evailable prior to Completed 24a. Wes en autopsy performed? hills completion of cause of death? 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Division or Attending 5 Pending investigation 1 Natural 2 Accident 124 hours after death. • Funeral Director: Afti detely filled in by the fur 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 3 MO JANUARY 2 /, 2000 012532 30. Name and address of person who completed caugh of death (Item 23a) (Type, Print) Tais 912 Seton Drive, C Breza Greorge umberland, MD 21502 31. Date filed (Month, Day, Year) JAN 2 8 2000 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** HOWARD ABBOTT BITTNER, SR. JANUARY 24, 2000 ation of Death 4c. County of Death /Medical 1235 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY SACRED HEART HOSPITAL If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 8. Data of Birth (Month, Day, Year) Days 15 M 20 F Months 214 14 8000 78 Director JUNE 16 1921 MARYLAND Usual Rasidance of Decedant 10b. County 10d. Inside City Limits 10a. Stata 10c. City, Town or Location "natural", or items 23s or 28s-f show adical Examiner must be notified at XX Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 63 GRANT STREET 21532 U.S. Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ሺ Yas 2 □ No. # Yas, Giva WW II Yaar or Datas: 14. Race - American Indian, 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, atc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental hygiene. Important: if them 27 la marked other than "naturany injury or other traumatic event, in Medical pages. Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Collega (1-4or 5+) Elemantary/Secondery (0-12) 12 MAINTENANCE HOSPITAL 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) GILBERT BITTNER MARY SMITH 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAVID BITTNER / SON 19408 MAPLE RIDGE DRIVE, SW, FROSTBURG, MD 21532 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Ramoval from Stete 4 Donetion 5 Other (Specify) FROSTBURG MEMORIAL PARK 1/27/00 FROSTBURG, MD 21532 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause on sech line. Approximata Intarval Between Onset end Death **Physician** Immediate Causa (Final disaasa or condition resulting in daath) /Medical Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laeding to immadiata cause. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760 Dua to (or as a consequence of) USB P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Trae 2 No 3 Probably 4 Unknown Pulmanary of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Certification: To Be Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa retarred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 Impatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Panding investigation death. 1 Yes 2 No 2 Accident after deat Director: 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 0 24 hours a Funeral D etaly filled Medical 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29b. Signetura end titla of certifier 29d. Data signed (Month, Day, Year) 29c. Licensa number 23 30. Nama end addrass of person who completed causa of daeth (Item 23a) (Type, Print)

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State Registrar Mander Sandhir

JAN 2 7 2000

48 Tarn Terrace

32. Registrar's Signature

Frostburg, MD 21532

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Year **Physician** Joseph Jerome BURKEY 27 JANUARY 2000 08:45 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yo August 3 Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 17 M 2□ F 217-10-4139 84 30,1915 Maryland Director Usuel Residence of Decedant the Maryland 10a. Steta 10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at MD Allegany Cumberland 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 715 Gephart Drive 21502 U.S.A. death v Funeral 14. Rece - American Indien, 11. Maritai Status Was Decedent Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nost of Health and Mertal typione. And if Itam 27 is marked other than "natural", or the ary or other traumatic avent, the Medical 1√2 Yes 2 No If Yes, Give 1 Never Merried 3 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced Year or Dates: 1941-45 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Celanese Fibers Spinning Dept. 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Jerome Joseph Burkey Mary Katherine Muller 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Rosemary Burkey/Wife 715 Gephart Dr. Cumberland, MD 20b. Plece of Disposition (Nama of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Steta 4 Donation 5 Other (Specify) Department of Important: If any injury or page. Cumberland Crematory 1/29/00 Cumberland, MD 21. Signeture of Funerel Sarvice Licensee 22. Nama and Addrass of Facility Upchurch Funeral Home, P.A. SMark Se 202 Greene St. Cumb. MD 21502

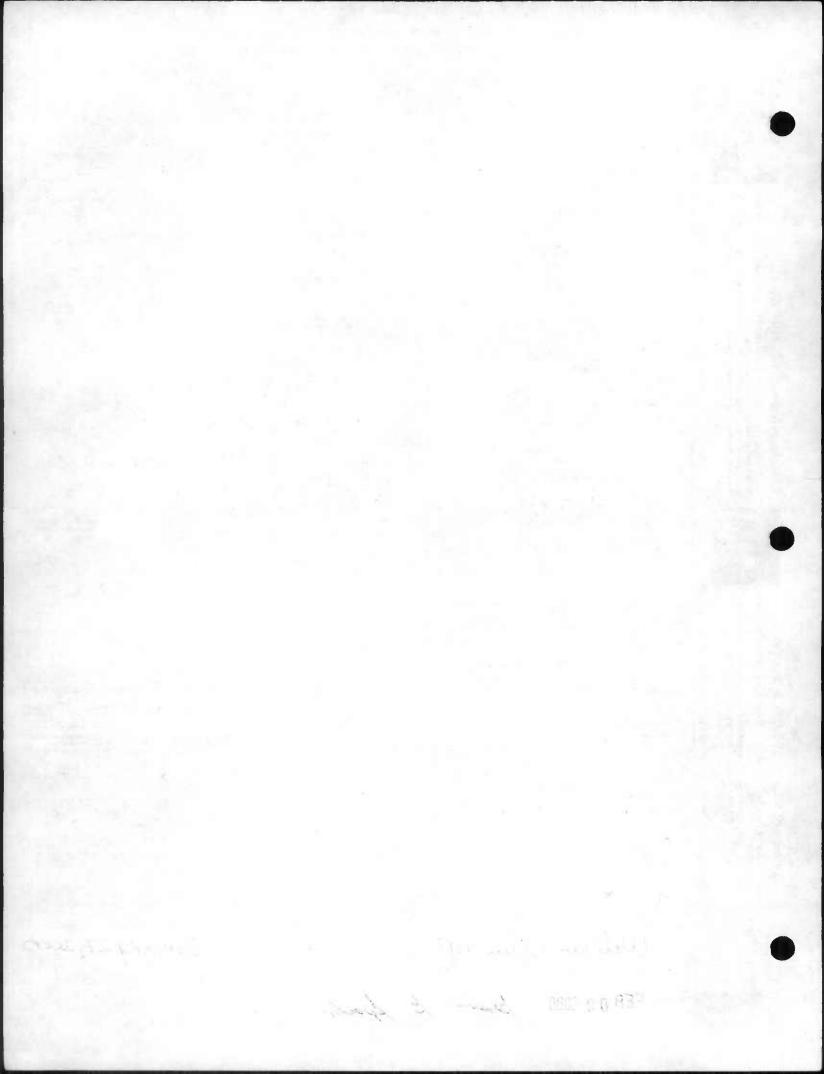
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heer failure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) s. Hepatorenal Syndrome 2 weeks **Examiner** Due to (or es e consequence of): Examiner Hepatic Cirrhosis 20 years ician and burial-transit that the death certificate be assocuted Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Lsst Dua to (or es a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, edical Dua to (or as a consequence of): 217-10-4139 been signed by the attending p should be detached for use as Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à or Attanding Physician: The law requires Completed 24a. Was an eutopsy performed? 24b. Wera autopsy findings eveilable prior to completion of cause of death? paga 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Wss case reterred to medical exeminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA After this 28d. Describe how injury occurred 27. Menner of Death 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Neturei 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Cartifian tely (Check only one) within 2. To the F 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signetura end titla of certifier 2000 lu M JANUAR D 25406 30. Name end address of person who completed causa of death (item 23a) (Type, Print) Mis WILLIAM D. LAMM, MD 47 VIRGINIA CUMBERLAND, MD 21502 AVE., 32/Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

BURKEY

JOSEPH

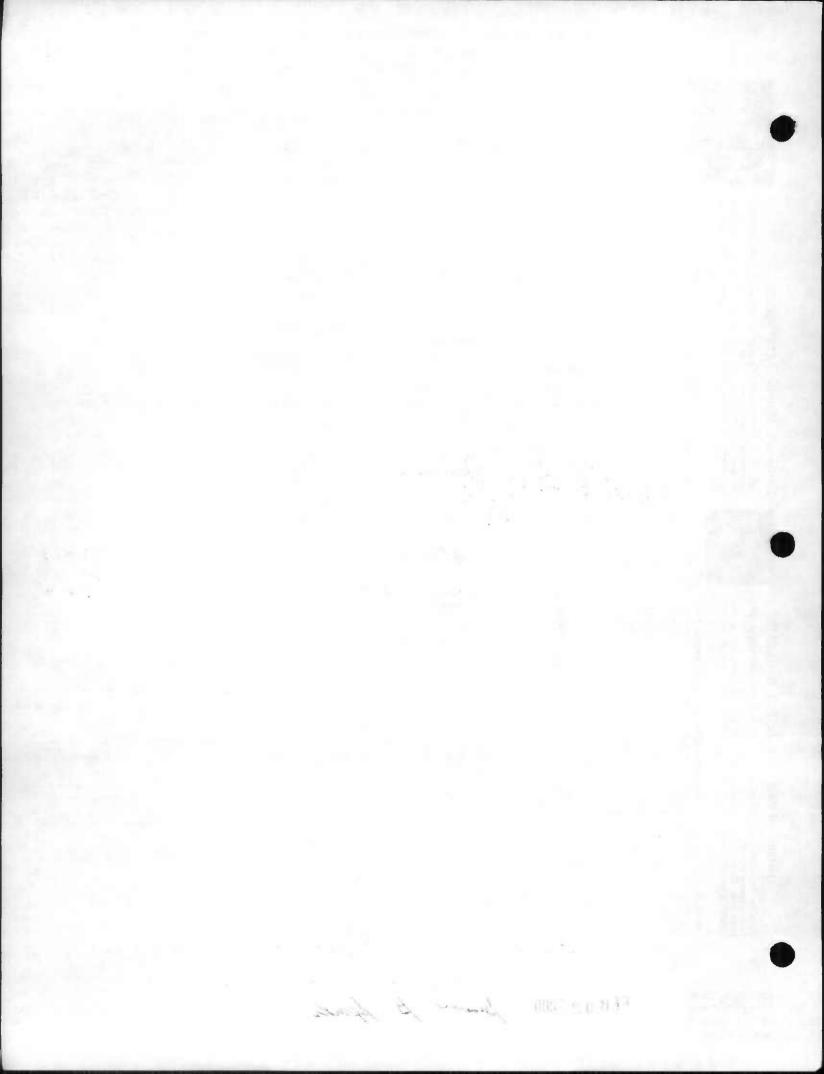


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Minola Charlotte Baker /Medical 4b. City, Town, or Location of Death 30 2000 4c. County of Death 5:25 PM 4a Facility Name (If not institution, give street end number) **Examiner** Devlin Manor Nursing Home Cumberland MD Ir Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Allegany 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex **Funeral** 10M 20F Days Months Director 214-05-7420 July 20, 1903 the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Manylan and ned the Hydineo.
and of health and Mental Hydineo.
mit: if term 27 is marked other than "natural", or fitems 23a or 28a-f ahow
inty or other traumatic event, the Manical Examines must be notified as Yes 2□No Directo MD Allegany Cumberland, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 624 Fairview Ave. 21502 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca -12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: by **X**□Widowed 4□Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stockroom Supervisor 6 Retail Store ne (First, Middle, Maiden Sum 17. Father's Name (First, Middle, Last) Be Clarence F. Seeders Anna Matilda (Aldridge)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Gladys Baker 626 Fairview Ave., Cumberland, MD 21502 permit. Pages 1 en Department of Heali Important: If item 2 any injury or other DDCS. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method ol Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify Hillcrest Memorial Park 2/2/00 Cumberland, MD Name and Address of Facility
Kight Funeral Home 309-311 Decatur St., 21 Signature of Funding ice Ligat Cumberland, MD 21502 all bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): 10 Examiner ach The law requires that the death certificate be executed physicien and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending for use as signed by the a Part II. Other stanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert t 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ils certificate has b I director, paga 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4-Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 -Natural efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Dis completely filled in 29a. Certifier 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 5 tu. 1, 2000 117565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nus NIEI 7 1 n O 922 AJ Bollin 32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Biack indeible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Yea **Physician** 20, 2000 Gail January 4:15 AM Ann Bell /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Viconico Salisbury If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Deys 1 M 2 TF Director 216-90-0616 April 12,1969 Maryland Usual Residence of Decedent with the Maryland hygiene. Wher than "natural", or flems 23a or 28a-f show ent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Maryland Delmar 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 32549 Melson Rd. 21875 USA death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural", or its any Injury or other traumatic event, the Major. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Child Day Care Provider 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leroy Stark Barbara Henderson 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles C. Bell Jr./Husband 32549 Melson Rd., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom State Salisbury Crematory 1/22/00 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury, MD 22. Name end Address of Fechity Holloway Funeral Home Professional Association Funeral Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 Enter the disease, or complications that cause of the complex of the complex on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death **Physician** OVARIAN CANCER /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as e consequence of) the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown should be date Records, Aq 24b. Were autopsy lindings aveilable prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? cartificate 28 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Netural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) illed in by 4 Homloide Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier complataly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) the 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Mue Solis mo 1104 31. Dete liled (Month, Day, Year)

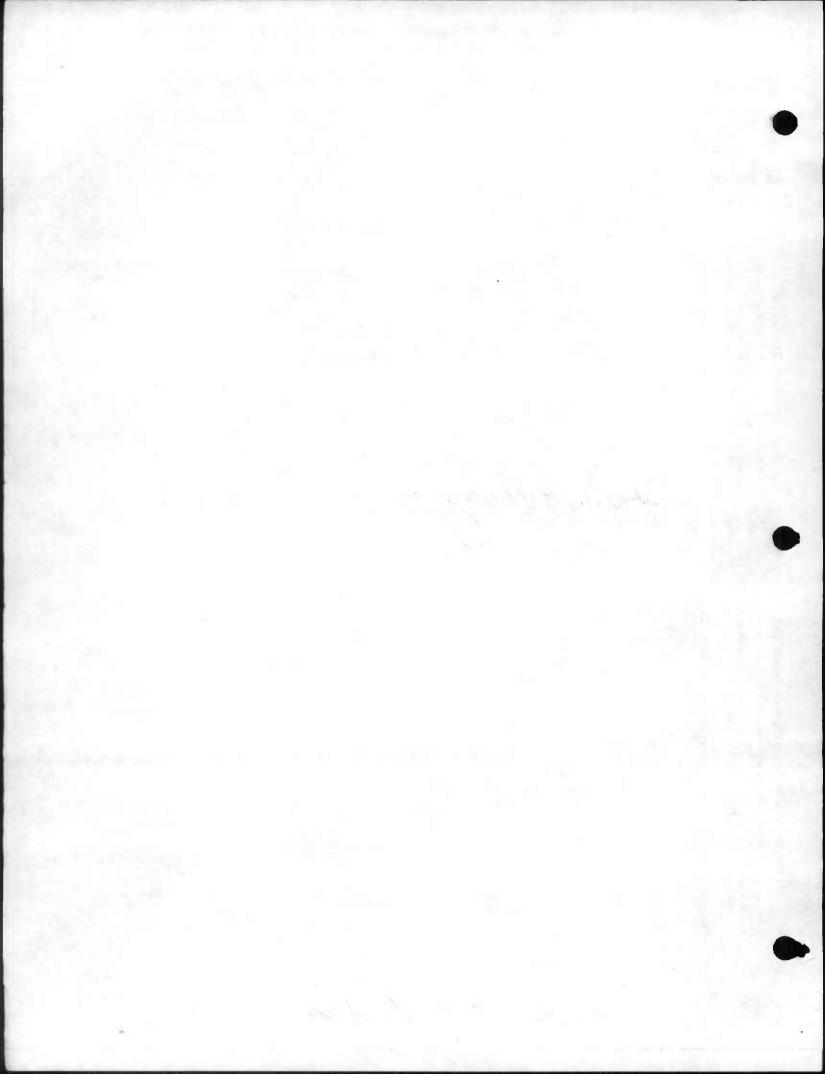
**DHMH 16 Rev 6/95** 

State

Registrar

32. Register's Signature

JAN 2 4 2000



30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) 5 MARYSOUTA 31. Dete filed (Month Day, Year) 32. Registrar's Signatura State JAN 2 4 2000 Registrar

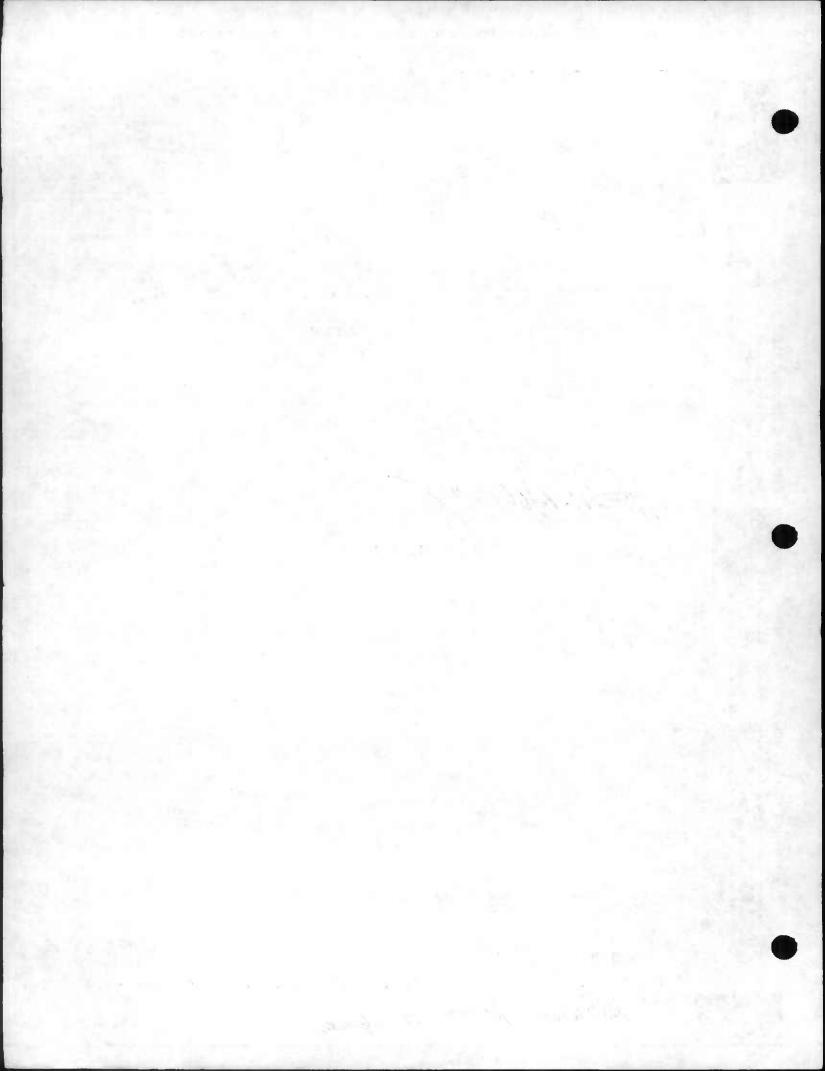
Colow M111 Penn Street, Baltimore, Maryland 21201

January 21, 2000

O.C.M.E.

Sports

**DHMH 16 Rev 6/95** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death JANUARY 21 2000 01:10AM William 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Baltimore If Under 24 Hrs. If Under 1 Year Months Days 5. Sociel Security Number 6. Sex № M 2□ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 52 577-62-6247 D.C. Usuel Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits Delmar 1 Yes XX No Sussex De. 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 19940 RD#1 Box 184 E. Line Road 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give 1 Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No 965-1966 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Fire Dept. College (1-4or 5+) Elementery/Secondery (0-12) Fire fighter 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Richard Bingham, Sr. Ida Lloyd Bingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Retetionship (Type, Print) RD#1 Box 184 E. Line Rd. Delmar, De. 19940 Wendy J. Bingham, Wife 20b. Ptace of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 1-25-2000 Delmar, Md. Melsons Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. llean 13 E. Grove St. Delmar, De. 23a. Pert1. Enter the disease, or complications thet causshock, or heert failure. List only one ceuse on each Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Respiratory Due to (or as a consequence of): yoglobulinemia Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hepatitis Die io (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medicat examiner?\ 26. Place of Death (Check only one) No No Other; 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Neturet 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined

Examiner burial-transit that the death certificate be executed and P.O. Box 68760 Physician/Medical the signed by the Division of Vital Records. p Completed Be Certification: To this

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

28a-f

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Berne 23a

'natural', or

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permit. Pages 1 and 2 should be liled w Department of Health and Mental Hygien, Important; if Item 27 is marked other the any injury or other traumatic

**Physician** /Medical

Examiner

altimore, Maryland 21215-0020

Hospital or Attending Physician: hours after death. ni bellif filled in n 24 hou.

6+1VA

within 2 4

State

Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

29b. Signeture and little of certifig

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Baltimore, MD 21287

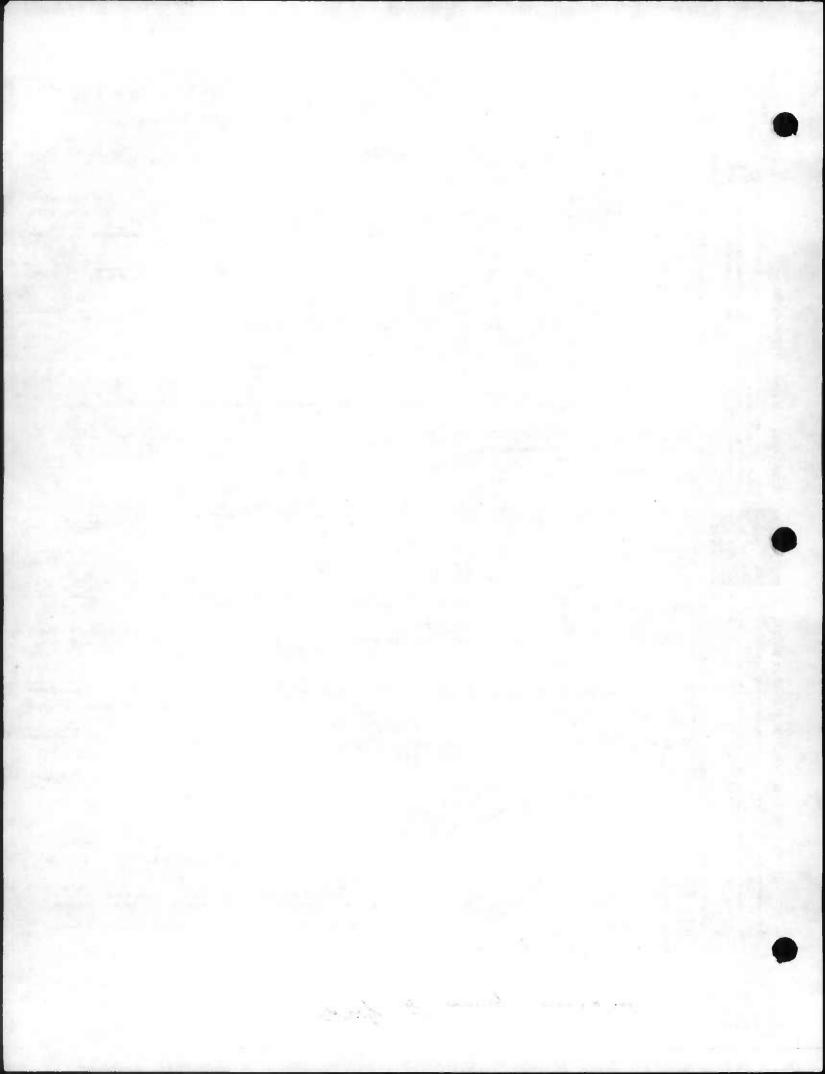
28l. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

SMITH rain 31. Date filed (Mobil), L 2 4 2000

600 NAGh 32. Registrar's Signature

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Amend item#5 2/14/00 HCHD BRH 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Ruby Brooks 05:29 PM Feb 744 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County Enton انى If Undar 1 Yaar | If Undar 24 Hrs. Social Security Number 218-32-5000 2:4-32-5000 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North Carolina 7. Aga (In yrs. lest birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs. **Director** 76 Usual Rasidance of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner naut be notified at 1X Yes 2 No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 147 Bannister Street 21001 Herns 23a U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. should be filed within 72 hours effer on Mental Hygiene.

marked other than "natural", or He 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 1 ☐ Never Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White p 3 Widowed 4 □ Divorced Completed traumatic event, the Musical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be Pages 1 and 2 should be fament of Heelth end Mental int: if Item 27 is merked of James E. Grace Lura DeBoard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) nt of Heelth e if Item 27 is or other tra Nancy J. Greer (Daughter) 147 Bannister St., Aberdeen, Maryland 21001 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 2/11/00 Aberdeen, Maryland 21. Signature of Funeral Service Licensae 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part . Enter the disease, or complications that caused a shock, or haart failure. List only one cause on each the he death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final 20203 7 days winary disaasa or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner physician end s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consaquance of): P.O. I Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t stage reusi disease Records. þ cate has been significant page 2 should b 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 1 ☐ Yes 2 No 1 Yes this certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Maryner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No invastigation 2 Accident efter death 3 Suicide 6 Could not be datermined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homleide To the Hospital within 24 hours e To the Funeral C completely filled 1 Certifying Phyatcian: To tha best of my knowledga, daath occurred at the time, data and place, and dua to tha causa(s) and manner as stated.

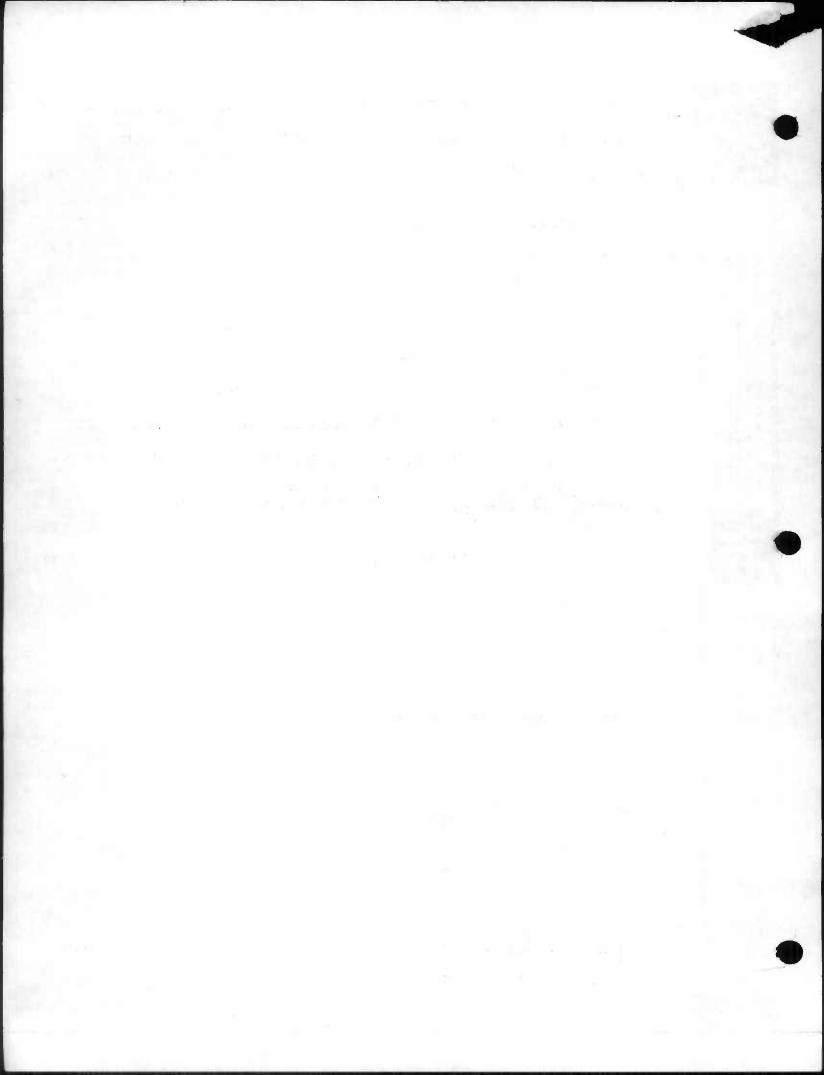
2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date and place, and dua to the causa(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) Feb. 744, 2000 mD) 47471 30. Name and address of person who complated ceuse of death (item 23a) (Type, Print) Agrou, wo Joshua W 31. Date filed (Month, Day, Year) FEB 9 2 32. Registrar's Signatura

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**DHMH 16 Bay 6/95** 

State

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year BEAMAN Kuth 2000 :10 Am tebrussey 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital 7. Age (In yrs. last birthday) Months Days Havre de Grace Harford | Hunder 24 Hrs. | 6. Data of Birth (Month, Day, Year) | 9. Birthpl Count Birthplace (State or Foreign Country) 212-50-5411 4/9/1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Harford Darlington 1 Yes 2010 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Hughes Road 21034 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, Whita, etc. 1 ☐ Yes 2000 If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: SpecifWhite 3XD¥idowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 3 years 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Charles Glassman Josephine (Unknown) 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Miller- daughter 3503 Hughes Rd., Darlington, MD 21034 20b. Place of Disposition (Nama of cemetary, cremetory or other plece) 20a. Method of Disposition Deta 20c. Location - City or Town, State MBurial 2 Cremation 3 Ramovel from Stefe Dublin Southern Cem. 2/10/00 Darlington, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme and Address of Fecility Harkins F.H. Inc., 600 Main St., Delta, PA 23a Part LEnfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart feiture. List only one cause on each line. 17314 Approximete Intervel Batween Onset and Deeth Aspiration lungs a Asphyxia Immediete Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown L'eumatord arthutis 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Dementa SIP G'Tube placement 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Examiner physician and the buriel-transit Physician/Medical signed by the e Records, certificate Vital or Attending Physicien: to this Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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al Hygiene.

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29a. Certifier (Check only one) 29b. Signeture and title of certifier

4 Homicide

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

MIRZA A-BAIG

29c. License number

29d. Date signed (Month, Dey, Year)

2-8-00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Havre De Grace, MD, 21078 Ave Unin

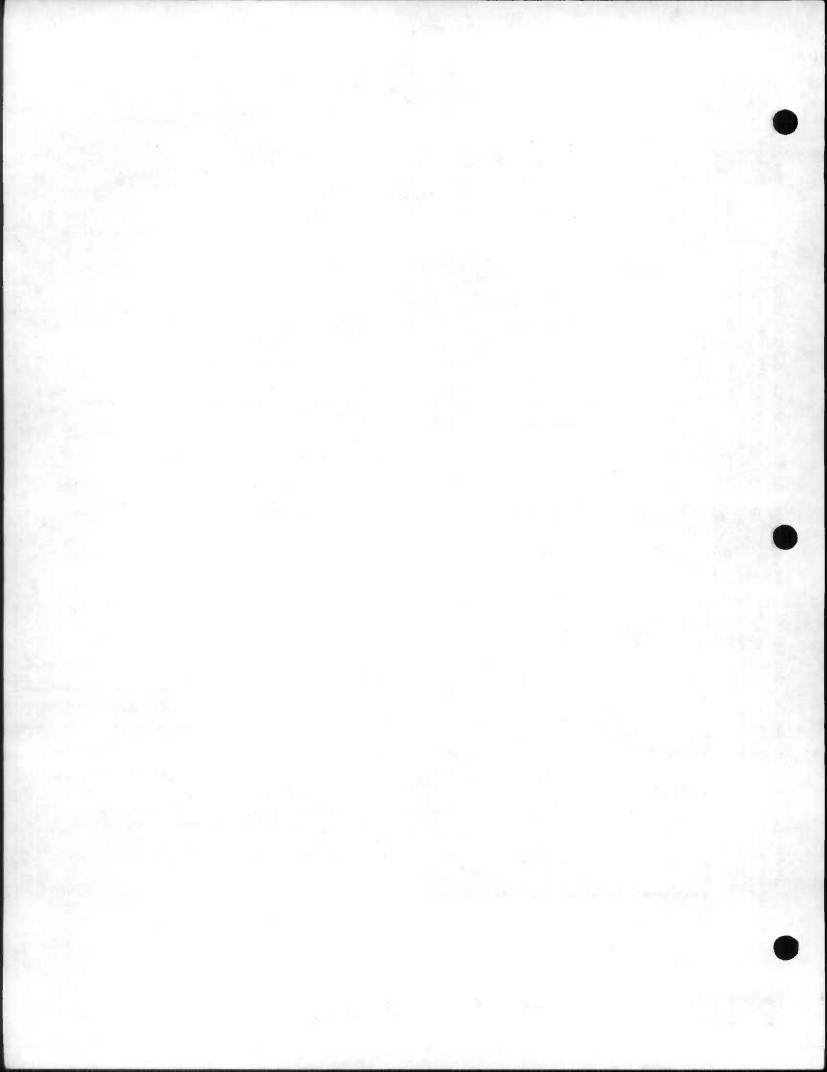
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Maryland Harford Forest Hill    10e. Street and Number   10f. Zip Code   10g. Citizen of What Country?   10g. Citizen of What		1. Decedent's Nama (First, Middle, Las	it)		tificate of		2. Dete of Deet		1	3. Time of Death
46. Firstly Name of root institution, you series and unsteady  46. Poly, Town, or Location of Death POPONES HILL  47. POPONES HILL  48. South Sacratify Windows  49. South Sacratify Windows		Nettie Kil	by Brow	m						7:024 11
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17. Father's Name (Pratt, Middles, Last)   18. Mother's Name (Pratt, Middles, Marchae, Marc	dim.	Eiementery/Secondery (0-12)		lifa. L	OO NOT usa retire	during most of wo	rking			,
John David Killby  Jee Informert's Name/Relationship (Type, Print)  MaceLine B. Rullis Daughter  252 Putnam Rd., Forest Hill, Maryland 21050  266 Marked of Disposition 1 (Demonstrated Section 1) (	e C			110110		18. Mother's Ne	me (First, Middle, M			
Madeline B. Bullis/ Daughter  2527 Putnam Rd., Forest Hill, Maryland 21050  10 page 10		John David Ki	.lbv			Della M	Mae Brow	n		
MacGelline B. Bullins Daughter 2527 Putnam Rd., Forest fill, Maryland 21050  Based and biospecial proposition (Name of Carabitors)  Approximately contained from Stete of Cross Poace State Stat	9 =			19b. Meilin	g Address (Stree				State, Zip	Code)
1 Remains   2 Ceremetion   3 Removal from Stetic   Cross   Roads   Baptist Cerem.   2=10-00 N.   Wilkesboro   N.	d he	Madeline B. Bulli	s/ Daughter	252	7 Putnam	Rd., For	cest Hill	, Mary]	land 2	21050
4 Donation s Dher (Specify)  27. Name and Address of Facility  McComas Funerial Home, P.A.  1317 Cokesburry Road, Abincyclon, MD 21009  28. Part Enter the Survey, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiratory affect.  Immediate Cause (Final disease or conditions)  18. Sequentially list conditions, if any, leading to immediate cause final disease or conditions.  19. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  1   Yes 2   No 3   Probably 4   Units and a conditions contributes to the cause of death of the cause of death				Pleca of Dispos cematary, cran	sition (Nema of natory or othar pla	ce)	Data	20c. Location -	City or Tov	wn, State
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The state of the control of the co	Se C					26. Place of De	1	, ,		
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Kernit P. Bonorich MD D0005593 02-07-2000  30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)  K. D.	W Som	29b. Signetura and title of cartifier			29c. Licens	sa number	2	9d. Data signe	d (Month, E	Day, Year)
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Funeral Director	5. Social Security Number 6. S 218-05-8727	ex	ge (In yrs. last 90	birthday) Yrs.	If Under 1 Y Months Da	ear If Und	ter 24 Hrs. S Min.	8. Data of Birth (Month, Day June 25	,1909	9. Birthple Country Mary	lca (State or Foreign
8 .	Usual Rasidence of Decedent  10a. Stata 10b. County		10c. City, T							140	
shorts det		CO		uitla						10	d. Inside City Limits  1 ☐ Yas 2 ☐ No
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the with	PO Box 162					326			USA	What Count	yı
The 22	PO BOX 162  11. Marital Status  1 Nevar Married 2 Married	12. Was Decedent	Ever in U.S.	13. V			Origin? (Sp	scify Yas or No-		e - Amarica	n Indian.
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Baltimore, semit. Pages 1 at Separament of Hea moortament if Item, my injury or other most.	20a. Mathod of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	etery, crem	sition (Name of natory or other	place)			20c. Location -		
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Ball permit Departiment any in	21. Signature of Funaral Service Licen	10-	MOIDS	" He		7 Fune	ral H				sociation
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State	31. Data filed (Month, Day, Year)	32, Registy	rar's Signatura		4	,			7-5		

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death February Ist **Physician** 2000 4:35 pm BANKS LILLIAN ETHEL /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Wicomico Nursing Home if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 F Months 103 Maryland Director 221-03-1159 November 13,1896 Usual Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits Wicomico Salisbury Maryland 1 Yes 2 No Director 28a-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò flerns 23a 1216 Frederick Ave. 21801 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married "natural", or 1□ Yes 2 No Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Co-Owner Clothing Mfg. Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be arid Mental William Peter Wright Sally Weatherly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Belva B. Pusey/Daughter 1216 Frederick Ave., Salisbury, MD 21801 rportant: If Item 27 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 12/5/00 St. Stephens Cemetery Delmar, DE 22. Neme and Address of Facility 21. Signature el-Funeral Service Licensee M01051 Holloway Funeral Home Professional Association 23e. Pert1. Enter the disease, or complications thet/caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Agents of the disease of the disease of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Agents of the disease of the disease of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death **Physician** acteriscleratio Cardiovasculas Desease /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 255No this 27. Menner of Deeth Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Neturel 2 Accident 5 Pending investigation Hospital or Attending n 24 hours after death.
 Funeral Director: After bletely filled in by the fun 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 2-2-2000 D 29505

Registrar

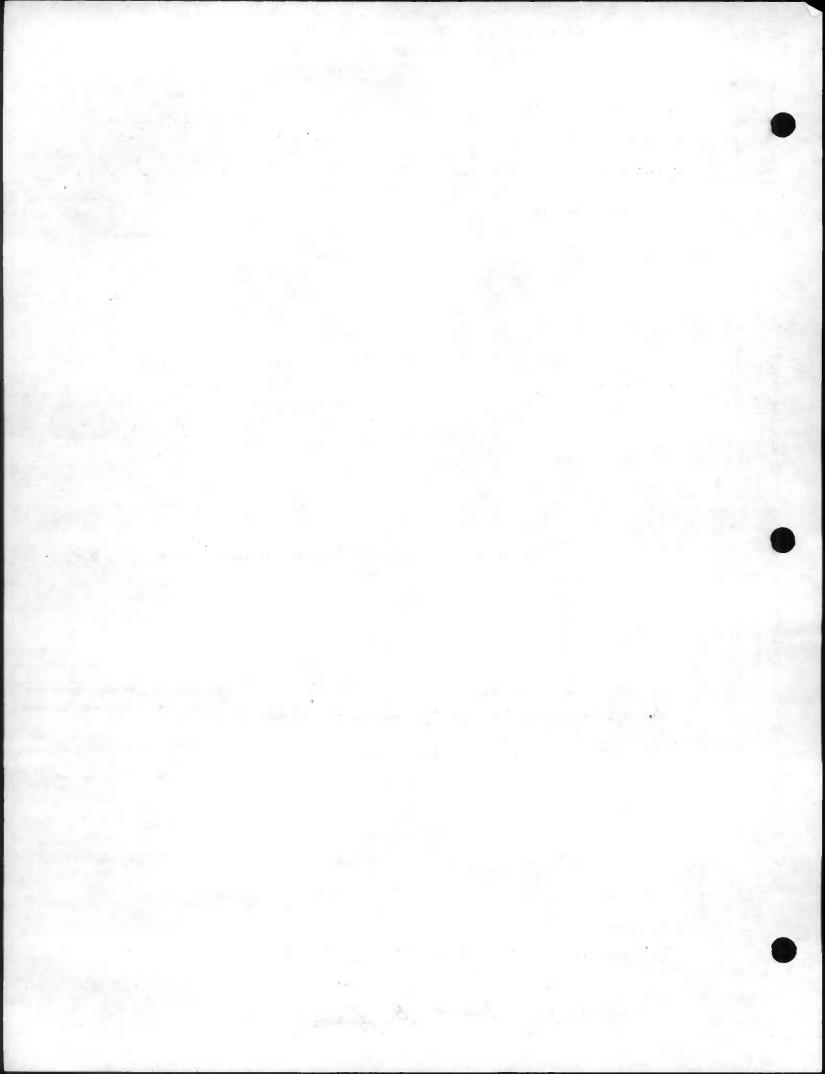
State

FEB 03 2000

31. Dete filed (Month, Day, Year)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR, SALISBURY, MD 21801 32. Registrar's Signeture

Name and ageress of person who completed cause of deeth (Item 23a) (Type, Print)



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 4a Fecility Name (If not Institution, give street and number C. Barcia 3:50 pm 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Sculsbury, N.D. Wiconcico Home Wicomico Nursing If Under 1 Year | If Under 24 Hrs. Months Devs Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 220-01-7198 10 M 2 AF Months Deys 94 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. inside City Limits Alisbur Tes 2 No DICOMICO Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 21801 0 Docth USA Funerai 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 1 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 20-AMELICAN À 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use (1979-d) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or.5+) CAMADAR RHURD 0 18 Mother's Neme (First, Middle, Maiden Surfame) 17. Fether's Name (First, Middle, Last) Be DONOHUE Kt 6 Noha E OLDERA 19e. Informent's Neme/Reletionship 19b. Meiling Address (Street and Number or Rural Route Number, 156 are 20b. Plece of Disposition 20a. Method of Dieposition ne of Date 20c. Location City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State MALG BM 100 4 ☐ Donetion 5 ☐ Other (Specify) 10 Smith 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee 51 Approximete Intervel Between Onset end Deeth CN nuce 23e. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory should be or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting to deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending investigation Injury 1 Yes 2 🗌 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

burial-transit and physician at the burial Box 68760. 980 datached Records, P.O. signed by t Division of Vital funeral death. or Attandi after death Director: A To the Hospital of Within 24 hours at To the Funeral D

**Physician** 

**Examiner** 

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Mexical Examinat must be notified at

d 2 should be filed within 7: th end Mental Hygiene. 7 is marked other than "no

permit. Pages 1 end 2 st Department of Health end important: If Item 27 is n any injury or other traun

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be Certification:

29a. Certifier (Check only one)

28e. Plece of Injury - At home, ferm, streef, factory, offica building, etc. (Specify)

1 (2 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted. 29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) GREGORIO

-30-2000 21801

State Registrar

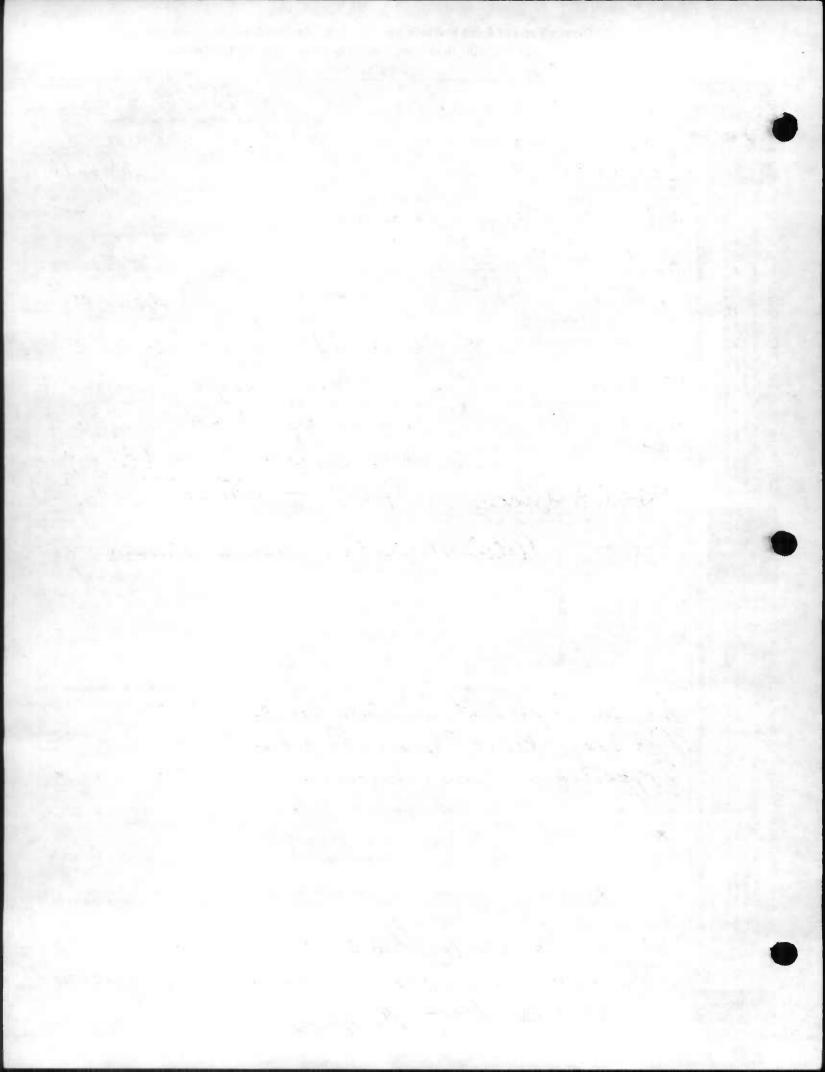
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Medical

31. Dete filed (Month, Day, Year) FEB 02

BELLOSO, M.D.; 5302 CHINABERRY DR

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #5/2-7-2000/WCHD/ HLC 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Helen Marie Bailey 5 February 2000 12:45 AM /Medicai 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 504 Village Court Salisbury Wicomico If Undar 1 Year Hundar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. Director 89 1910 Maryland Usual Residence of Decedent 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Mexical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Village Court 21801 Funeral U.S.A 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after inent of Health end Mental Hygiene.
ant: if item 27 is marked other than "natural", or itel
ury or other traumatic event, the Mental 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Oliver Dickerson Mary Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina Townsend (Caretakers) 29191 Waller Rd. Delmar, Md. 21875 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State % Mardela, Md. permit. Page Department of Important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) John Wesley Church Cem. 21. Signature of Funaral Servica Licensaa 22. Nama and Address of Facility Stewart Funeral Home 821 West Rd.Salisbury, Md. 21801 23a. Part1. Enter the disaasa, or complications that ceused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death rval Bet **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Physician/Medical Examiner the burief-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that Initiated events resulting In death) Last Dua to (or as a consequence of): US9 98 for is certificate has been signed by the director, page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown 2 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home & Residence 8 Other (Specify) Certification: To this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Records, of Vital or Attending Physician: Division To the Hospital or Attendivible Within 24 hours efter death.

To the Funeral Director: A

the

death

altimore, Maryland 21215-0020

State

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Yaar)

Registrar

5

completely

30. Name and address of person who completed cause of death (Item 23s) (Type, Print) MILTOR

FEB 0 7 2000

and manner stated.

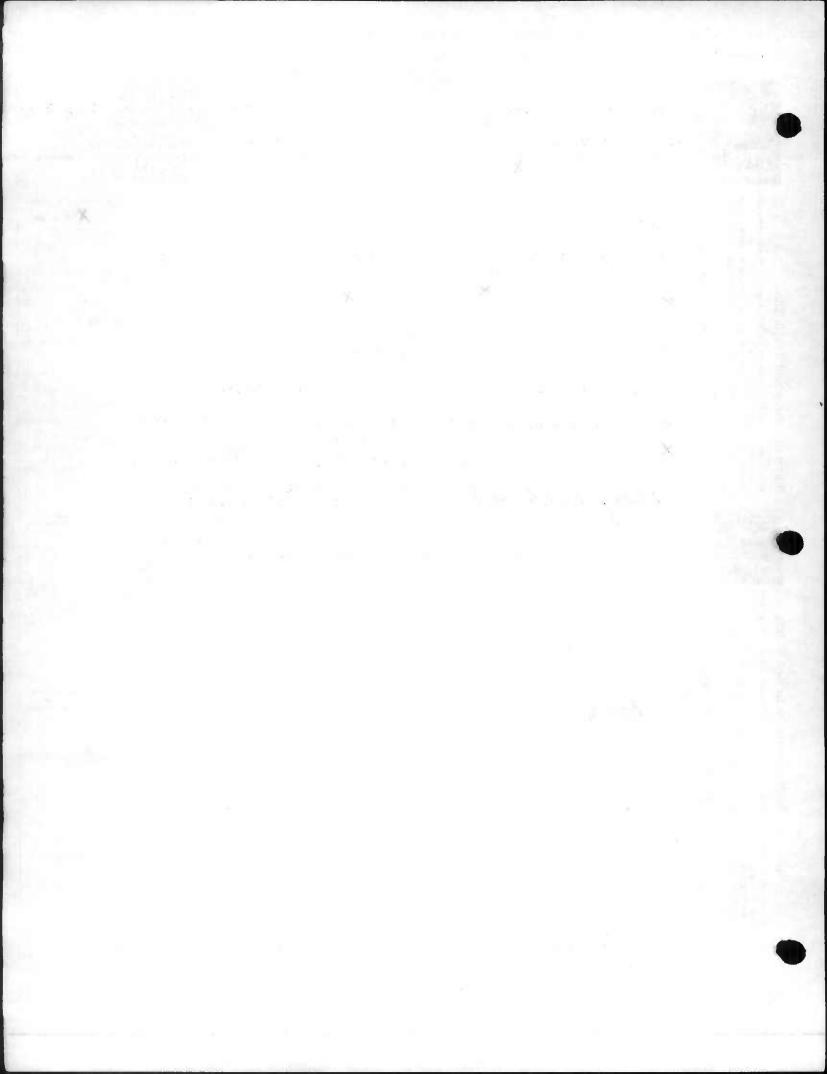
32. Registrar's Signature

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s)

29c. Licensa number

229105

29d. Date signed (Month, Day, Year)



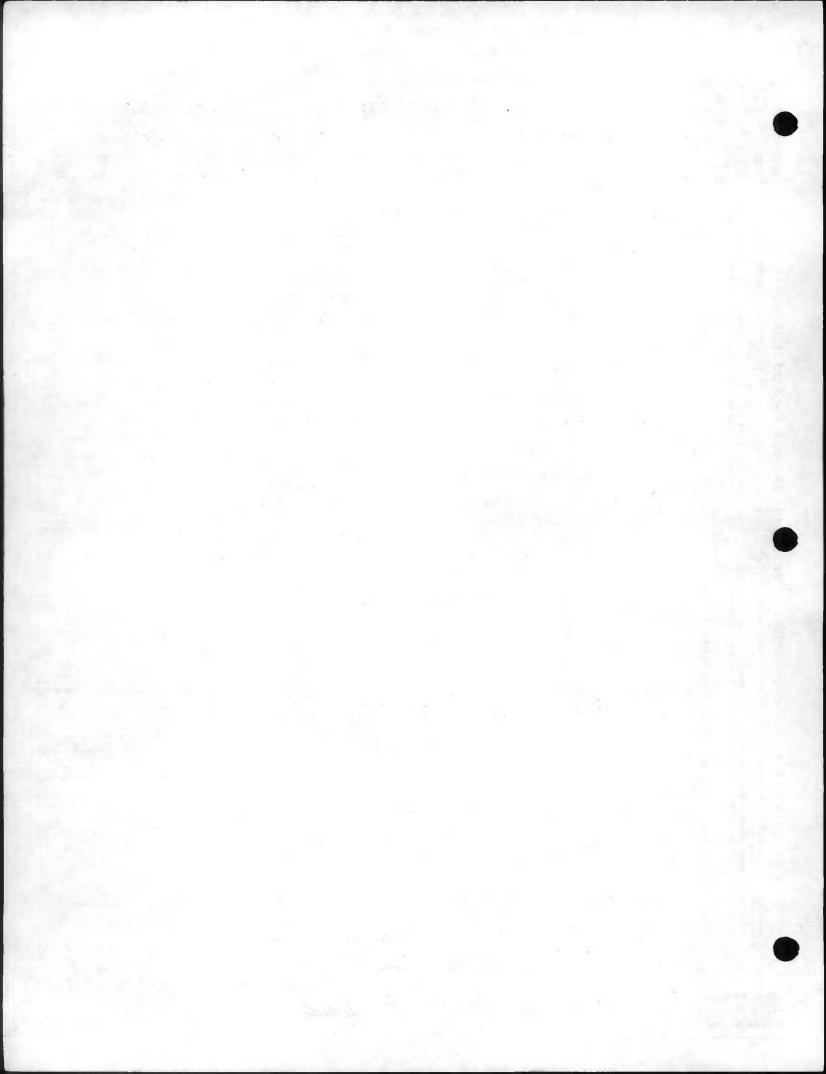
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State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 9 2

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	Wicomico Nursi	ng Home					Salis				omic	00	
neral	5. Social Security Number	6. Sex 1 ☐ M 2XX F	7. Age (In yrs.		Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Year)	9.	Birthplac	ce (State or Foreig
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þ	3 ☑ Widowed 4 ☐ Divorce	ed If Yes, C			1□ Yes	2√ No	Specify:			Sp	ecity:	Wh	ite
ted	15. Decede	ent's Education	41	16a. Dece	dent's Usue	ol Occup	ation	A of consta		16b. Kind	of Busine	ess/Indu	stry
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200	11	_		Hou	sewif	е				E	omes	stic	
Be	17. Father's Name (First, Middle								(First, Middle				
To	Thomas E. Hadd	der					Ca	ther	ine Ri	chards	on		
	19a. Informant's Name/Relation								al Route Numb				(ode)
	Alice K. Kenne	ey/Niece					Rd.,	Pars	onsbur				
	20a. Method of Disposition 13D Burial 2 Cremation	3 DRemoval from		Place of Disponentary, cre	osition (Nem matory or o	ne of ther plac	>e)		Date	20c. Locat	tion - City	y or Town	n, Stata
	4 Donation 5 Other (			ttsvil	lle Ce	emete	ery	2,	/6/00	Pitt	svil	le,	MD
	21. Signature of Funeral Service	e Licensee	MOIO	51 2	2. Name an	d Addre	ss of Facilit	y al H	ome Dr	ofossi	onal	1 700	cogiation
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edical Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant condit  Part III. Other significant condit    Death   Last	Hospital:    Hospital:   28a. Date (Molitigation of not be mined   28e. Plec built	Due to (or  Due to (or  Due to (or  death but not result of the control of the co	ER/Outpatie 28b. Time of injury whedge, deet tion and/or in	quence of): quence	DA Oth Rec. Injur Wor 1 Urg., office et the tin, in my on.	26. Please refer 4 M No. Yyat Yes 2 🗆	of Deeth	23b. Did 1 24a. War perl 1 1 Check only ma 5 Res 28d. Describe 28f. Location City or To	I tobecco us I tob	e contrit  No 3[  Other (1)  Occurred  Number of manne ace, and	bute to till Proba  24b. Were availe comported to the com	the cause of death the cause of death the cause of death the prior to plation of causa the plation of causa the cause (s)
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DHMH 16 Rev 6/95

Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Vera C. Barr FEBRUARY 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 M 2 T F 160-24-8179 73 Sept. 1, 1926 England Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2 No Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 West 8th Street 19956 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Office 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) John F. Clarke Blanche K. Norman Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, DE William S. Barr / Husband 103 West 8th Street 19956 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2-8-2000 Cambridge Crematory Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 23a. Part1. Enter the disease, or complications must caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause of each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Lusclinov Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown arture

**Physician** /Medical Examiner

signed by

Division

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f ehon

6 Items 23s

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filed within 7 Hyglene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mentel Hygient Important: if Item 27 is marked other tha eny linjury or other traumatic event, the J page.

the

72 hours efter

21215-0020

Baltimore, Maryland

Directo

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Completed

Be

Physician/Wedical by Completed 88 Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

24a. Wes an eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

2 1 No

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Sepatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? T SNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D1928

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

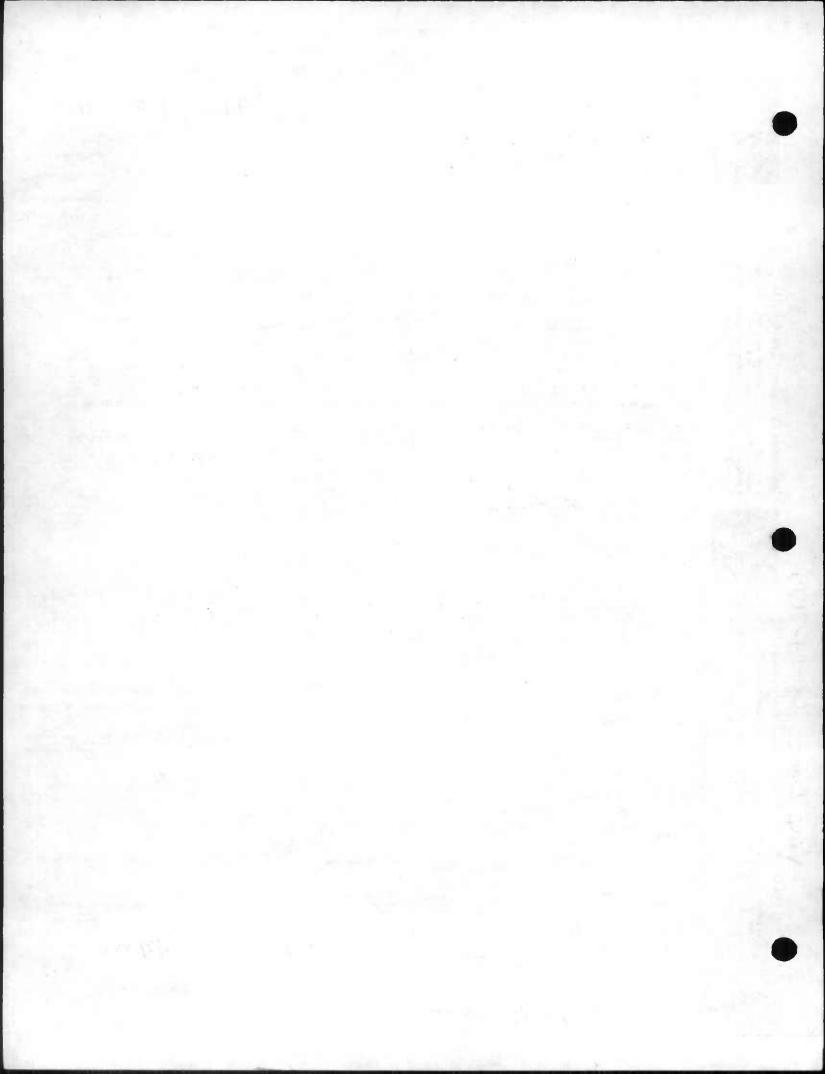
Drive Salisbary MD 21801 400 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

edical

29e. Certifier (Check only one)

To the Hospital
within 24 hours alta
To the Funeral Dir hours after



Please	Type or Print in State of Maryl	and / Dep	oartme	nt of		Mental Hyg		ble.	06194	
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EDISON	ROBERT	BEI	RGER			FEBRUAR	Y 11 2	2000	1:30 AM	
la. Fecility Neme (If not institution, give	re street end number)				4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
WATERVIEW HEALTH	CARE CENTER				SALISBUE	ΥY	WICOM	ICO		
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Jsuel Residence of Decedent  0e. Stete 10b. County	100	. City, Town or	Location					1	Od. Insida City Limits	
MARYLAND WICOMIC		SALISBI							1 Yas 2 No	
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7. Fathar's Name (First, Middla, Last, JOHN	BERGER				18. Mother's Ne	ma <i>(First, Middle, M</i> STALL	felden Sumen	ne)		
19e. Informent's Neme/Reletionship (FRANCES A. LUSBY					eet end Number or R ANIA AVE.	SALISBU				
Da. Method of Disposition  1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specif.  1. Signature of Fundant Strates Licentee	Ramoval from Stete SP		emetory or LL MEN	MOR	place) I GARDENS dress of Fecility	2/15/00	HEBRON	, MAI	RYLAND	
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ert II. Other significant conditions o	ontributing to death but not	resulting In tha	undarlying	causa	given in Pert I.	23b, Did to	4	3 ☐ Pro	the cause of death bably 4 Unknow	
						24e. Wes a perform	ned?	co of	ere autopsy findings allable prior to mpletion of cause death?	
5. Was case referred to medical					28. Place of De	eth (Check only on			46,10	
exeminer? 1 Yes 2 No	Hospitel:	2 ☐ ER/Outpati	ent 3 C	AOO	Other:	Home 5 Residence 8 Other (Specify)				
. Menner of Deeth  1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Yea	28d. Describe how injury occurred								
3 Sulcide 6 Could not be determined	28e. Placa of Injury - A building, etc. (Sp	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
9e. Certifier 1 Certifying Ph (Check only 2 Medical Exam	yelcian: To the bast of my niner: On tha basis of exam and menner steted.	knowledge, dee Inetion end/or l	oth occurred invastigation	d et the	time, dete end pleca y opinion, daath occu	a, end due to the courred at tha tima, do	ouse(s) and me ata and place,	enner as s and due to	tated. the cause(s)	
9b. Signatura and title of cartifiar			- 0	0- 11-	ense number	1 2	9d. Data signe	d /Month	O V1	

Division of Vital Records, P.O. Box 68760,

ate hes been signed by the attending physician and page 2 should be detached for use as the buriel-trensit The law requires that the death certificate be asscuted To the Hospital or Attending Physician: The law within 24 bours after deeth.

With The Funeral Director. After this certificate hes it completely filled in by the funeral director, page 2:

> 5 State Registrar

NATESAN, MI) 31. Dete filed (Month, Dey, Year) FEB 14 2000

Natar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiena. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Evanther must be notified as appared.

Physician

/Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

106 MILFORD 32. Registrer's Signetura

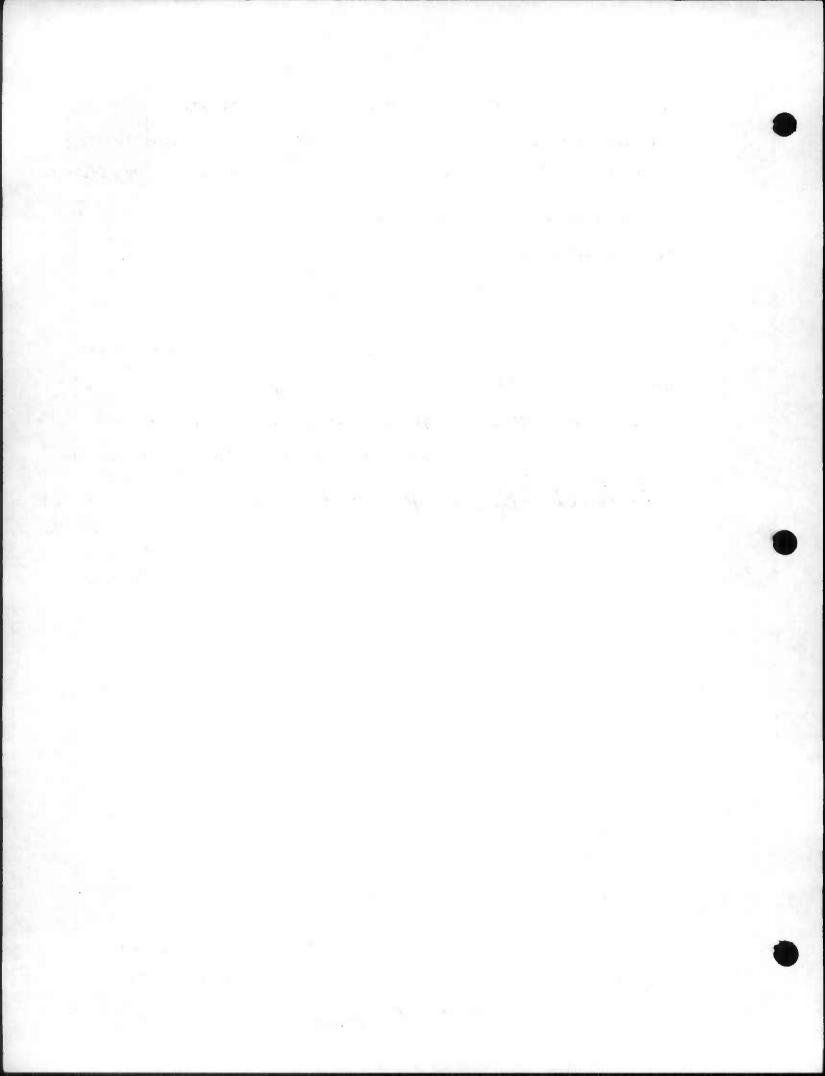
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SALISBURY MD 21804



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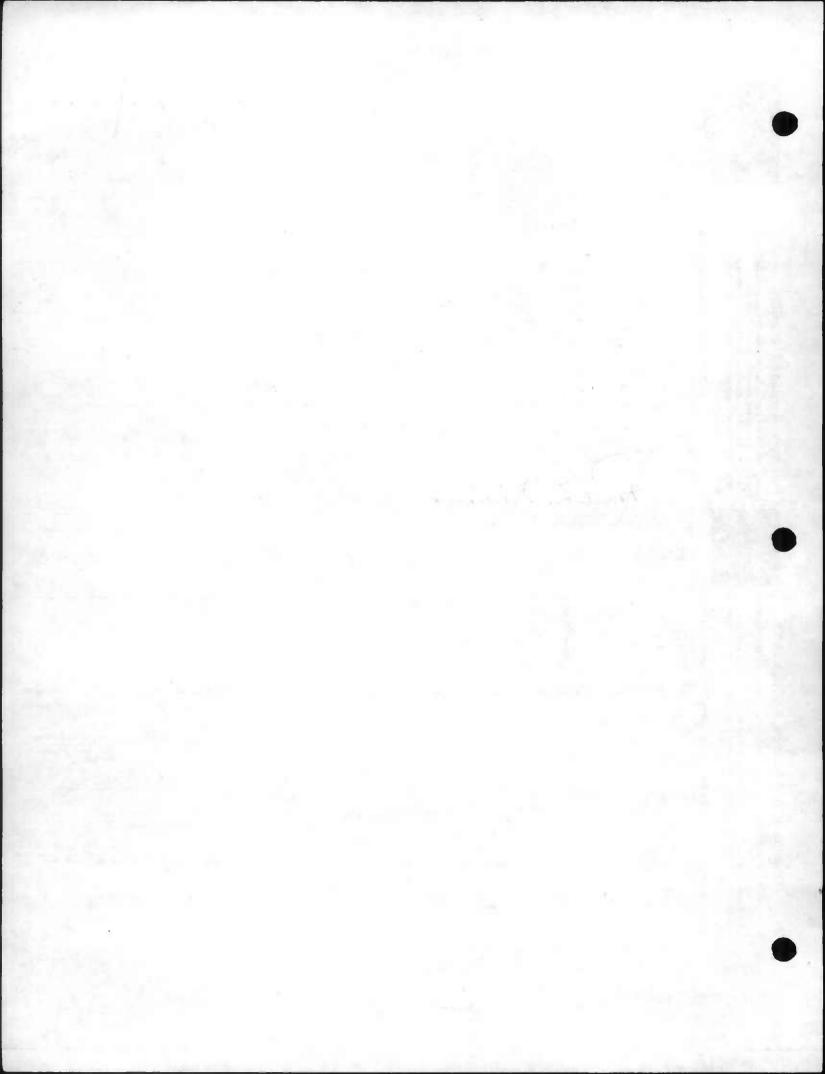
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Deeth **Physician** FEBRUARY 4, 2000 2:22 AM CAROL BARTOLET /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 10M 20XF Days Min Yrs. Director Sept. 23, 1941 Pennsylvania 195-32-0557 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or llams 23a or 28a-f show ideal Examinar must be notified at 1 Yes 2 No Director Maryland Frederick Keymar 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11648 Woodsboro Pike 21757 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ∑ Yes 2 No If Yes, Give Year or Detes: 1960-61 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "nath any Injury or other traumatic event, the Medica 000s. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Robert Bartolet Cornith Harvey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Campagna - Daughter 11648 Woodsboro Pike, Keymar, Maryland 21757 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) Metropolitan Crematorium 2/7/2000 Alexandria, Virginia 21. Signature of Funeral Survice Licensee 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home Villiam nert 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hand seiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Metustation mos Examiner Due to (or as e consequence of) Examiner physicien end a the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the sid be deteched for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown None Records. à 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? i certificate hes l 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hooptal or Attending Physicien: within 24 hours effer deeth.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, I 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO , walkasule, ml 2179 B0x 30 7 2000 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month DONALD WILLIAM BRANSFIELD SR. February 14,2000 11:10am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Yrs. 153-07-9453 80 Oct 10, 1919 Trenton, NJ Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 405 Clay Hammond Road 20678 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Yas 2 No If Yes, Giva 1 ☐ Navar Married 2 ☑ Married If Yes, Giva Year or Dates: 1941-45 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) store manager retail 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Bransfield Emma Hunt t9a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Evelyn W. Bransfield/wife same as # 10 above 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2-16-00 Metropolitan Crematory Alexandria, VA 21. Signature of Funaral Sarvice Licenty 22. Name and Address of Facility Williams Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute on Chronic Renal failure tmmediata Causa (Final disaasa or condition rasulting in death) Hypertensive Heart Disease you. Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated avents rasulting in death) Last Due to (or as a consequence of):

Diabete, mellitus Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Regrectory C. M. G. 1 Yes 2 No 3 Probably 4 Unknown A.S. H.D. S/p M.g. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? SID Amputation Ct. B.K.A. 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Panding

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

Box 68760

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Division of Vital

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permit. Pages 1 and 2 should be Department of Health and Mental Important. If Item 27 is marked of any injury or other traumetic ew

Directo

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Physician/Medical Be

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera

ALIX

**DHMH 16 Rev 6/95** 

Registrar

29b. Signatura and titla of certifiar M.P. Sheh

invastigation

6 Could not be determined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

D-22634

Location (Street and Number or Rural Routa Number, City or Town, State)

2-14-2000.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Prince Frederick, MD 20678 Dr. Mahesh Shah, M.D.

31. Data filed (Month, Day, Year) FEB 1 6 2000

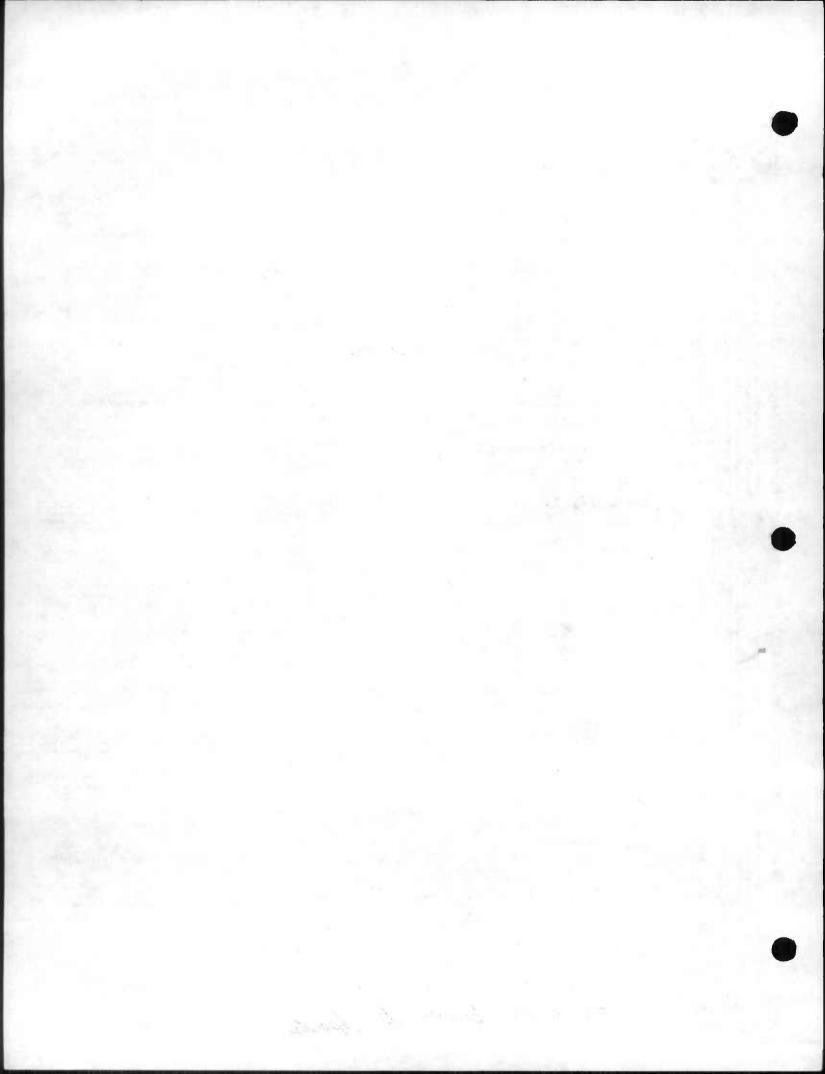
2 Accident

4 T Homicida

3 Suicida

29a. Certifier (Check only one)

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Year **Physician** LESTER **BROWN** LAMBERT **FEBRUARY** 2, 2000 4:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F Yrs. June 16,1913 215-09-1339 86 Virginia Director Usuet Residence of Decedent il Hygiena. other than "natural", or itema 23a or 28a-f ahow vent, the Medical Examiner must be notified at 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Frederick Mount Airy 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14704 Peddicord Road 21771 United States Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lifed within 7 Department of Health and Mentel Hygiena. Important: If item 27 is merked other than "ny eny injury or other traumatic event, the Mean and an Elementery/Secondary (0-12) College (1-4or 5+) Painter Painting Contractor 11 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell H. 0 Brown Marie Hudson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14746 Peddicord Rd./ Mount Airy, MD Carolyn Walker-Fitzgerald/niece 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State Locust Grove Cemetery 2-4-00 Mount Airy, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 8 E. Ridgeville Blvd./ Mt. Airy, MD elerion 21771 Part Form the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, about or haer failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediete Causa (Final UA 6- 4disease or condition resulting in deeth) D-24061-Examiner Due to (or as a consequence of): Examiner sicien and buriai-transit Sequentially list conditions, if any, teeding to immediata cause. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of) 88 P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be deta (0/07 Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case raterred to medical axaminer? 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 5 Pending 1 Neture 24 hours after death. Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c 1 icease number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of pertiller 014676 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

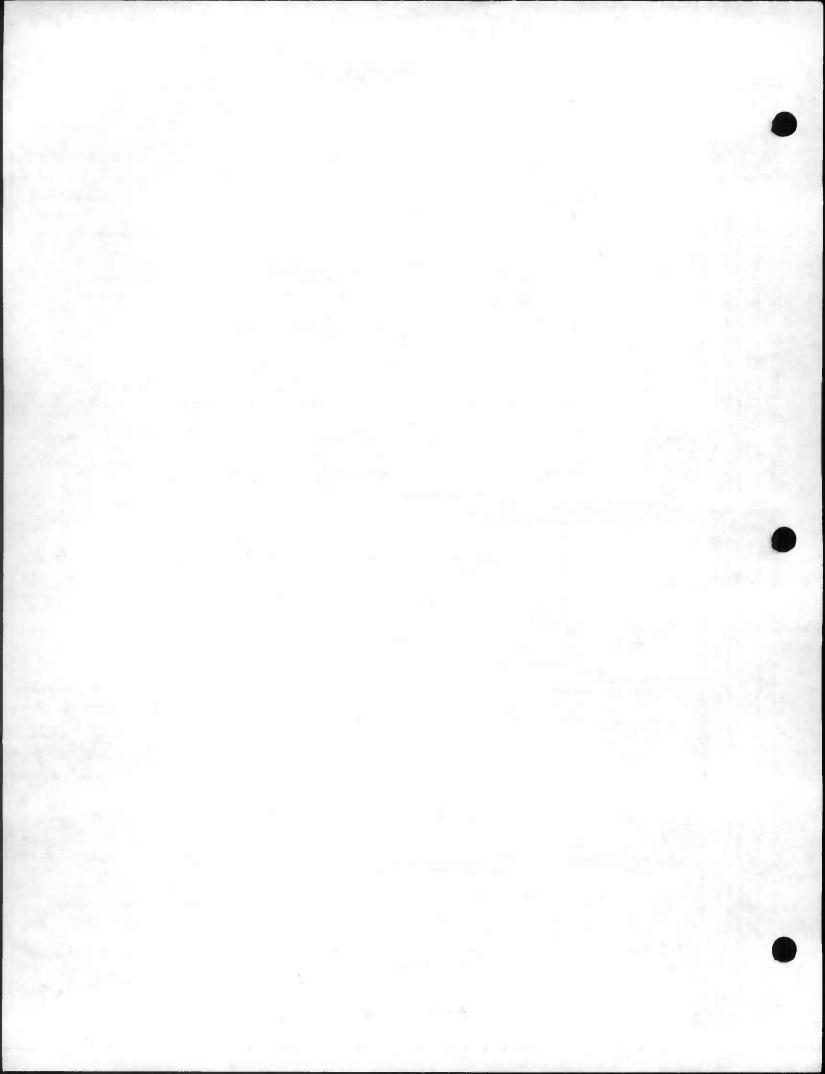
DHMH 16 Rev 6/95

State Registrar 501

Registrary Signature

7-105-5

4 2000

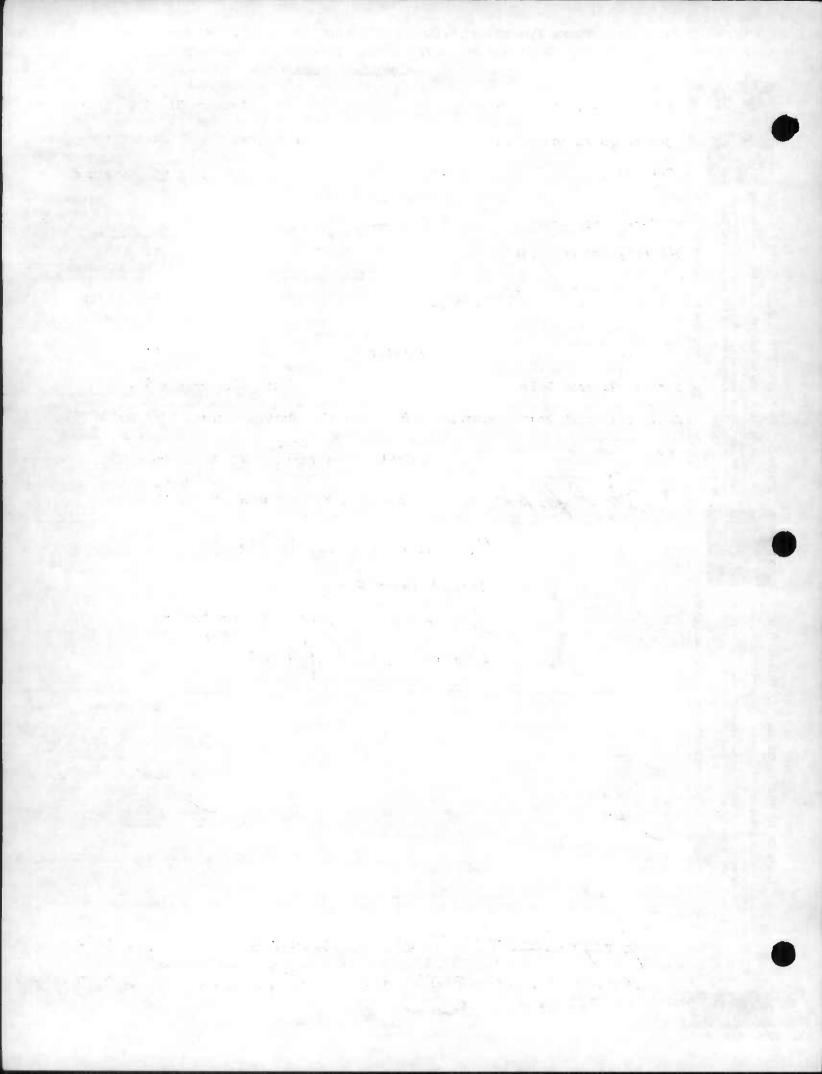


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State of Maryland / Department of Health and Mental Hygiene

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nvsician		. Decedent's Name (First, Middle, L	ast)						1	2. Dete of Deat Month	h Day	Year	3. Time of D	
/Medical	_	Robert Frankl	in Bai	ir					J	anuary	31 2	000	1:05	
Examiner	4	e Fecility Name (If not institution, g	ive street end numi	ber)				4b. City, To	wn, or Loca	ation of Deeth	4c. Coun	ty of Death		
		348 Pangborn Bo	ulevard					-	rstow			hingto		
ineral rector		. Social Security Number 6. 578-05-6241  Jsual Residence of Decedent	Sex 7	. Age (In yrs.	lest birthdey Yrs.	Months	Days	If Under Hours	Min.	B. Dete of Birth (Month, Dey, eb 11,		9. Birtho Cour Mary	otece (Stete or i otry) Land	
***		0a. Stete 10b. County		10c. City	y, Town or L	ocation						1	Od. Inside City	
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23a or 3	3	0e. Street and Number 348 Pangborn Bou	levard			101. 2	ip Code 2174	2			0g. Citizen of USA	whet Cour	ntry 7	
it, or items	2	1. Maritel Stetus  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	tryes, Give	es?		Was Dec	ecify Cub	lispanic Ori en, Mexican Specify:	gin? (Spec n, Puerto Ri	ify Yes or No- can, etc.)	Bi	ece - Americ eck, White,	etc.	
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avent, Be C		7. Father's Neme (First, Middle, Las	st)				18. Mother's Ne			First, Middle, I	Meiden Sume	me)	e)	
To B		Arthur Eugene Bair Kati							tie E	lizabet	h Wide	lows		
27 is mari or treumati T		19a. Informant's Name/Reletionship Katie Elizabeth	(Type, Print)	ughter						Route Number				
important: If item 27 is marked other than any injury or other treumatic event, the Managas.  To Be Compi	-	0e. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion 3  4 ☐ Donetion 5 ☐ Other (Special Control of	☐Removel from Si	20b. P	Place of Disp emetery, cre SSNIC	oosition (Ne emetory or	ome of other ple	ce) Cemt			20c. Location	- City or To		
mand the state of	1	23a. Part 1. Enter the disease, or co- shock, or heart feilure. List on immediate Cause (Finel disease or condition resulting in death)		ese	Grov or as a conse exfar	equence of	ules ~	1 he	cld	mf			Approximate Intervet Betwe Onset end De	
as the builded in the form	j	Sequentially list conditions, fleny, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury hat initieted events	c/	Strill Due to (or	mina rese conse	quence of	1018	hi	an	eury	zn	i		
tending physici or use as the but an/Medical		hat initieted events nesulting in deeth) Lest	d	Urron	ne	Neve	al	fail	une					
ached ached hysi		hat initieted events not be a conditional to the conditions of the conditions	dcontributing to dea	Ohror	ulting in the			V			becco use o	/	o the cause of bably 4 □ U	
igned by the be detached by Physi	P	resulting in deeth) Lest	contributing to dea	Unrov	ulting in the			V		23b. Did to	es 2 No	3☐ Pro		
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ne Funeral Director: After this certificate has been signed by the plately filled in by the funeral director, page 2 should be detached edical Certification: To Be Completed by Physi	F 2	Part ti. Other eignificant conditions  25. Was case referred to medical examiner?  1	Hospitai: 1 In Indian 28e. Dete of (Month, on be do building) Physician: To the barriner: On the bes	patient 2 Injury Dey Year) If Injury - At ho, etc. (Specify est of my kno is of examine or stated.	ER/Outpetie 28b. Time Injury ome, farm, s	ent 3 Cof	cause gi	26. Plece her: 4 Nury et rk?  Yes 2 me, date en opinion, dee	e of Death ursing Hom No	23b. Did to 1 V 24e. Was e perion 1 V (Check only or e 5 Teside ad. Describe had due to the code at the time, described and due to the code at the time, d	obecco use of the second of th	3 Pro  24b. Weyer confidence of 11  24b. Weyer confidence of 11  whither (Special confidence of Runner of	dere eutopsy fin relieble prior to impletion of cardeath?  Yes 2014  fy)  al Route Numb  steled. o the ceuse(s)	



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death February 8, 2000 **Physician** Helen Louise Baugher 8:30 am /Medical 4a Facility Nama (Il not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Hours Days 1□ M 2♥ F Director 214-10-1212 89 Sep 21, 1910 Mary Land Usual Residence of Decedant with the Merylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director Maryland Frederick Frederick 1 Yes 2 No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 300 Redwood Avenue 21701 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 XNo If Yes, Give 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, tre Medical Essen Black White, atc 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White py 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Drug Store 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willard Morton Beall Myrtle Rosalia Geisinger 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Paula Ross/Niece 11402 Meeting House Road, Myersville, MD 21773 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20a Method of Disposition Data 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Rocky Hill Cemetery Feb 11, 2000 Woodsboro, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Nama and Address of Fecility
Keeney & Basiord P.A. Funeral Home M00706 or Devzer 106 East Church St, Frederick, Maryland 21701 23a. Part Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart ailura. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Ynn Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last that the death certificate be execu Box 68760. Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by the 1 Yas all No 3 Probably 4 Unknown Records, à 24b. Ware autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? page 2 1 Yes 25 No 1 ☐ Yas 2 ☐ No certificate Division of Vital after death.

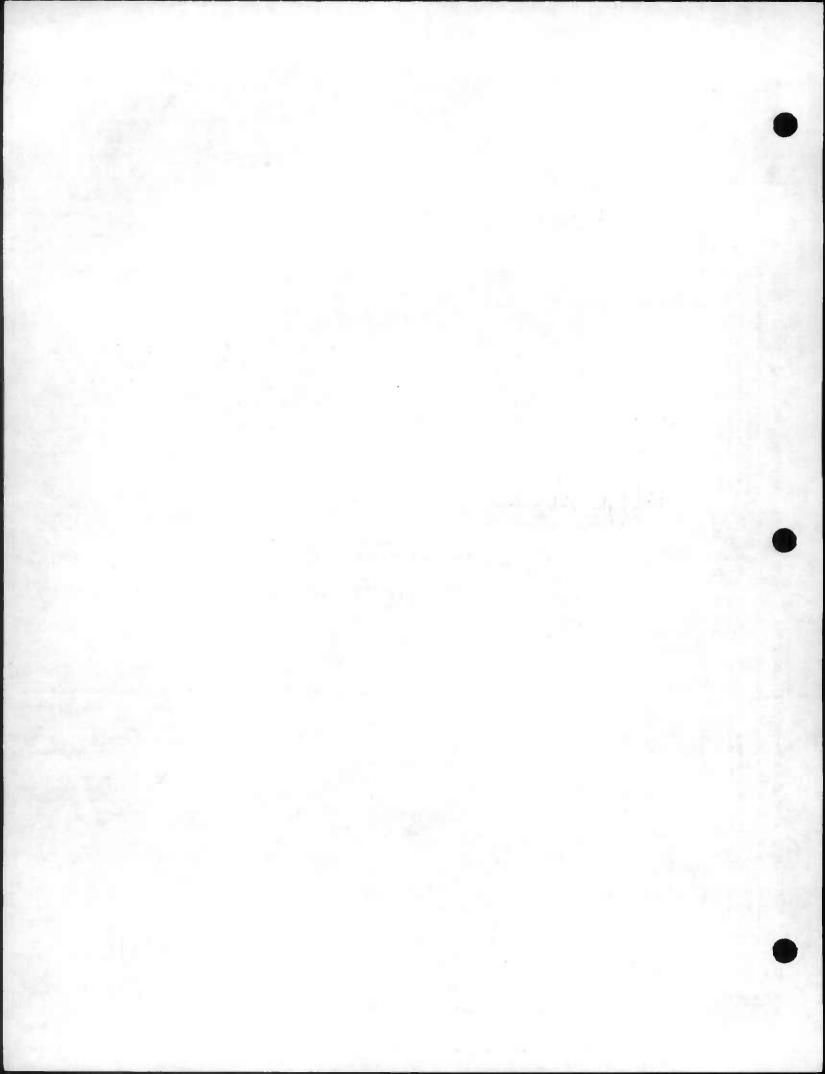
Director: After this certifica director. 25. Was case rafarred to medical axaminer? Be 26. Place of Death (Check only one) Other: 6 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yas ANO Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 2 4 Homicida S To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) end manifer steted. 29b. Signeture and the of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D16428 114 30. Name and address of person who completed cause of death (Name 23a) (Type, Print)
Casper E. Cline III, M.D., 300 West Nin 300 West Ninth Street, Frederick, Maryland 21701

Registrar **DHMH 16 Rev 6/95** 

State

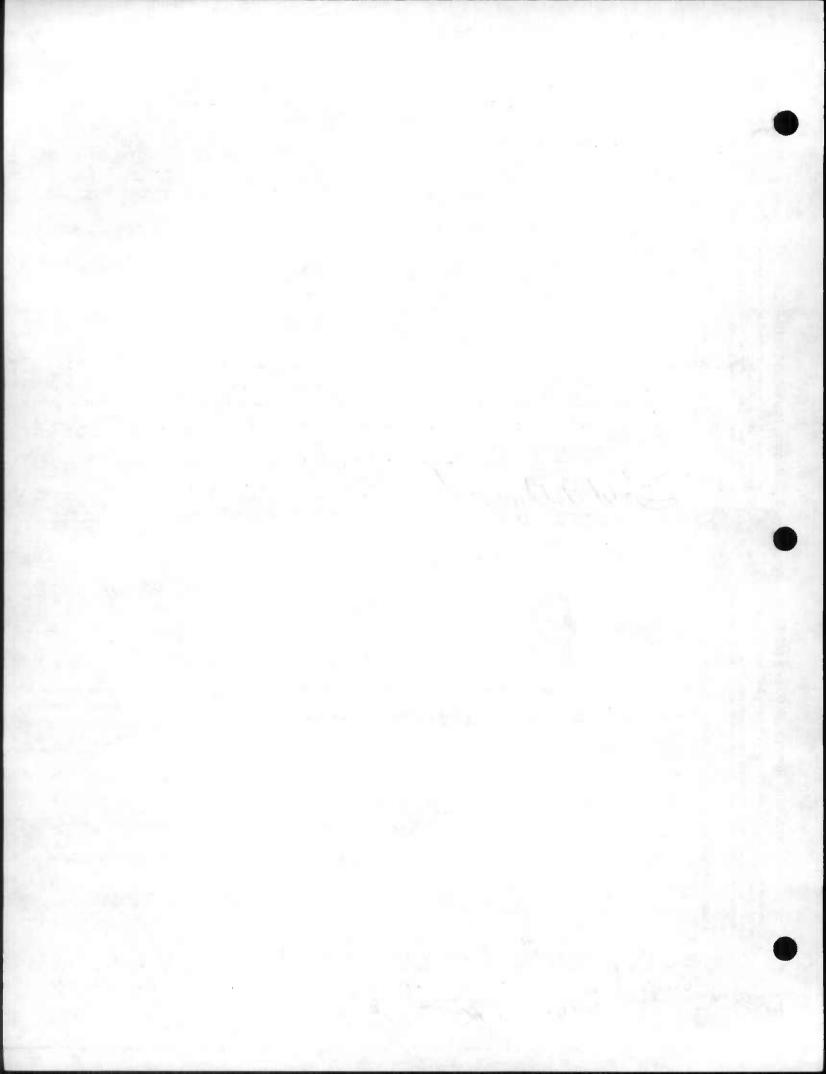
31. Dete filed (Month, Day, Year)

9 2000 Registrers Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.6200

100				Certificat	e of Death		g. No.	0 802	.00
Physician	Decedent's Neme (First, Middle, La.	cosman			2. Date of Death Month	Year 3. Time	a of Death		
Physician /Medical	Susan L.			2 PM					
Examiner	4a Facility Name (If not institution, giv	4b. City, Town, o	February 1, 2000 5:  4b. City, Town, or Location of Death 4c. County of Death						
	Frederick Memori	ol Woonite	1		Free	ierick	E~	ederick	
Funeval	5. Social Security Number 6. S		(In yrs. last bii	rthday) If Under		rs. 8 Date of Birth	77-		te or Foreian
Funeral Director		□ M 2⊠ F	43	Yrs. Months	Days Hours M			9. Birthplace (Sta Country)	
Director	Usual Residence of Decedent		7.7			riay 12,	1930	Pennsylva	ania
2 2	10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside	City Limits
of day									as 2⊠No
of the	Maryland Frederi	LCK	Ijams						
a or 28a-f show be notified at Director	10e. Street and Number			10f. Zip	Code	10	g. Citizen of W	/hat Country?	
229 E	3529 Green Valley	Road			21754	1	United	States	
E 5	11. Marital Status	12. Was Decedent E	iver in U,S.	13. Was Deced	lent of Hispanic Origin? lify Cuban, Mexican, Pu	(Specify Yes or No-		- American Indian	1,
F.	1 ☐ Never Merried 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ N	0	The second		erto racan, etc.)	Riac	k, White, etc.	
à	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠ No Specify:		Specify	White	
	15. Decedent's Ed	turation	16a	Decedent's Usua	al Occupation	1	8h Kind of Bu	isiness/Industry	
Completed	(Specify only highest gra	ide completed)		(Give kind of wor	rk done during most of w	vorking			
É	Elementary/Secondary (0-12)	College (1-4or 5-	H)						
ပိ	12			Home	maker		Own H		
Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ieme (First, Middle, M	aiden Sumem	Θ)	
P	George Brooks				Mary Mo	cGarry			
	19a. tnforment's Name/Relationship (	Type, Print)	19t	. Mailing Address	(Street and Number or	Rural Route Number,	City or Town,	State, Zip Code)	
	Michael Cosman/ H	ushand	35	29 Green	Valley Roa	d Tiomorr	1110 N	lawri land	21754
	20a. Method of Disposition	assana	20b. Place o	Disposition (Nan	ne of	Date 2	Oc. Location -	City or Town, State	21/24
	1 ⊠ Burial 2 ☐ Cremation 3 ☐			ry, cremetory or o		1			
	4 Donation 5 Other (Specify		Resth		orial Garde	ns 2/5   I	rederi	ck, Mary	land
8	21. Signature of Funeral Service Licer	usee /			Mo 1 o arrant	-1 D A T-		77	
1	epdel M	1 km/11		26401	. Moleswort Ridge Road,	Damaccuc	Maryl	and 208	72
	23s Part 1 Enter the disease or com-	nlication and caused	the death Do					Approxi	
- 10	23a. Part1. Enter the disease, or com shock, or heart feiture. List only	one called on each lin	Β.					Interval	Between nd Death
an al	Lucia Control Control	i i							
ar er	Immediate Cause (Final diseasa or condition	sch	Ehic	CALL	CARDIO.	ATITY		1	
	resulting in death)		Due to (or as a	consequence of):					
Examiner		A1-	TERILEC	skotic	CARDIO.	MASCULAL	DIS	180 SE.	
E	Sequentially list conditions			consequence of):		0.,			
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							1	
-	Cause (Disease or injury that initiated events	c						1	
edicai	resulting in death) Last		oue to (or as a	consequence of):				1	
-		d						1	
2									
0	Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the underlying c	ause given in Part I.	23b. Dtd tob	acco use cor	tribute to the cau	se of death?
Physician/N	1		~			1□ Ye	2 No	3 □ Probably 4	- Onknow
by P	INSULIN DEP	SN DENT	DIABE	7ES M	ELLITUS				
D D						24a. Was an	autonev	24b. Were autop	sy findings
Completed						perform		available pri completion	or to
وَ								of death?	20,110,120
0						1 □ Yes	2 1 No	1 ☐ Yes	2□ No
	25. Was case referred to medical			-	26 Place of E	Death (Check only one	1		
o Be	examiner?	Hospital:		4N 5 - 5 - 5	Other				
2	1 Yes 2 No	1 L Inpatier	t 22 ER/O		A   4   Nursing	Home 5 Resider			
Certification:	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b.	Injury	8c. Injury at Work?	28d. Describe hov	w injury occurr	ed	
at	2 Accident investigation			М	1 ☐ Yes 2 ☐ No				
Ĕ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.		orm, street, fectory	, office	28f. Location (Str. City or Town,	et and Numb	er or Rural Route f	lumber,
-	/	bullarily, etc.	(Opoury)			, , , , , , , , , , , , , , , , , , ,	0,0,0,		
100	29a, Certifier 1 Certifying Ph	vaician: To the best of	my knowledge	a. death occurred	et the time, date and pla	ice, end due to the car	use(s) and me	nner es stated.	
edical	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examination an	d/or investigation,	in my opinion, deeth oc	courred at the time, de	te and plece, o	end due to the caus	se(s)
Ž.	29b. Signature and title of certifier			200	. License number	20	d Date sinner	i (Month, Day, Yea	e)
	250. Signature and little or certifier	- A1 .		290	. Labelse Hullipel	29	O a /	I (MONIII, Day, 188	")
	Gene /	wh b	D. V	PhA	DIOS8  AFFAIRS	7	02/0	3/20	00
	30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)		FREDERICE	- HEA	3/20	HOSP
	Co	4.3	1,00	DASE L.C.	AFFAIR	GREAGE	- 1	) 2.5	d 1
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06201 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death v 5,2000 **Physician** February 12:25 PM LYNN CROCKETT /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7022 Brantley Drive Salisbury Wicomico If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months Director 49 219-56-7801 November 22,1950 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d, Inside City Limits 1 ☐ Yes 2 No Director Maryland Wicomico 28e-f Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or herne 23s or 7022 Brantley Drive 21804 USA Funeral 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. filed within 72 hours after of Hygiene. ther then "netural", or the 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Specity: White Baltimore, Maryland 21215-0020 1 Yes 2K No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important if Item 27 is marked other the any linjury or other treumsitic BellAtlantic 12 Consultant 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Glen Walter Campbell Audrey Ann Dorman 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blair L. Crockett Jr./Husband 7022 Brantley Dr., Salisbury, MD 21804 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location · City or Town, State 1 ⊠ Burial 2 □ Cremetion 3 □ Removel from Stete 2/8/00 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) Parsons Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Holloway Funeral Home Professional Association M01051 23a. Pert1. Enter the disease, or complication, that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. arro 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examine Due to (or as e consequence of) Examiner ettanding physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) P.O. ed by the detached Part II. Other significant conditions contributing to death but not resulting In the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 □ Yas No 3 □ Probably 4 □ Unknown Records. þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes an eutopsy performed? Completed certificate has b 1 Yes a No 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To this 27. Magner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Avetural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) hours efter 4 | Homicide To the Hospital o within 24 hours eff To the Funerel Di completaly filled in adicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as steted.

I Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier 29b. Signature and the procertifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and a

Registrar **DHMH 16 Rev 6/95** 

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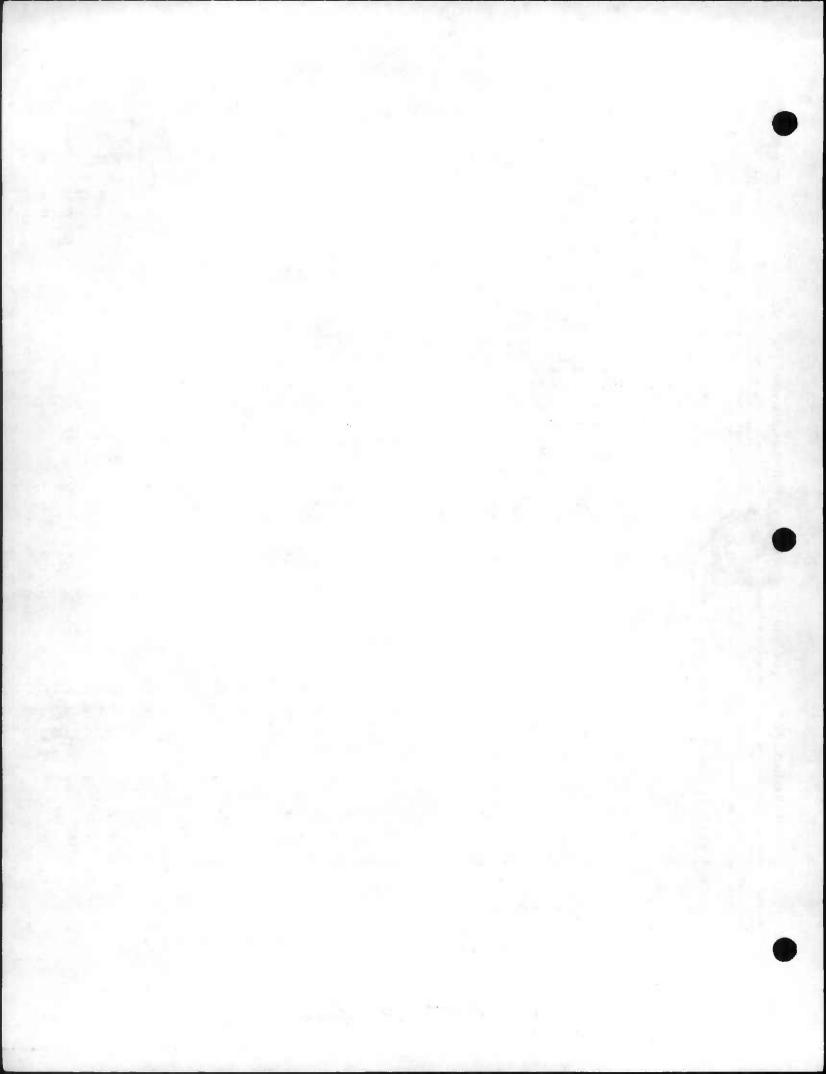
on who completed cause of death (from 23a) (Type, Print)

32. Registrar's Signeture

GRASSD

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #8, 2/7/00, WCHD, HLC 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** THOMAS JAN. 2000 WILLIAM CHERRY 27 11:15PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER; GENESIS ELDERCARE SALISBURY, MD. WICOMICO If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 10M 20 F 100-16-9813 Director Usual Residence of Decedent 1/1920 with the Maryland 10a. State 10c. City. Town or Location ms 23a or 28a-f ahow 10d. Inside City Limits Director 1 1 Yes 2 No Comuco 115bak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 180 5 A Funeral Herns : 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status permit. Pages 1 and 2 should be tiled within 72 hours aftard Department of Health and Mental hygienn. Important: If Itam 27 ia marked other than "natural", or then any injury or other traumetic avent, the Medical Examina Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Detes: 2 No Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: À AMELIGIAN 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) JANITOR Elementary/Secondary (0-12) College (1-4or 5+) bol (0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 80 Silliam Lomas 0 MAR 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number of Rural Plpute Number, City or Town, State, Zip Code) N.J. 07065 8 eleste ue 20b. Plece of Disposition (Name of certifier, cremetory or other 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Durial 2 Cremation 3 Removal from State 4 RMKTERC 200 10 Hurlock 4 ☐ Donation 5 ☐ Other (Specify) eture of Euneral Service Licensee 22. Name and Address of Facility Sm md unco Approximete Internal Between Onset and Deeth Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final UN9 CANCER disease or condition resulting in death) Examiner Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be asscuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown been signed by should be detac 1 Yea 2 No 3 Probably mentar þ Records. Completed 24b. Were autopsy findings available prior to 248. Was en autopsy performed? completion of cause of death? page 2 certificata 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No edical Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 8 Other (Specify) this this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No **2** □ Accident Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) FEB 0 7 2000

29b. Signature and title of certifie

MININGERS

1104 HEALTHWAY DR., SALISBURY, MD. 21804 32. Registrar's Signature

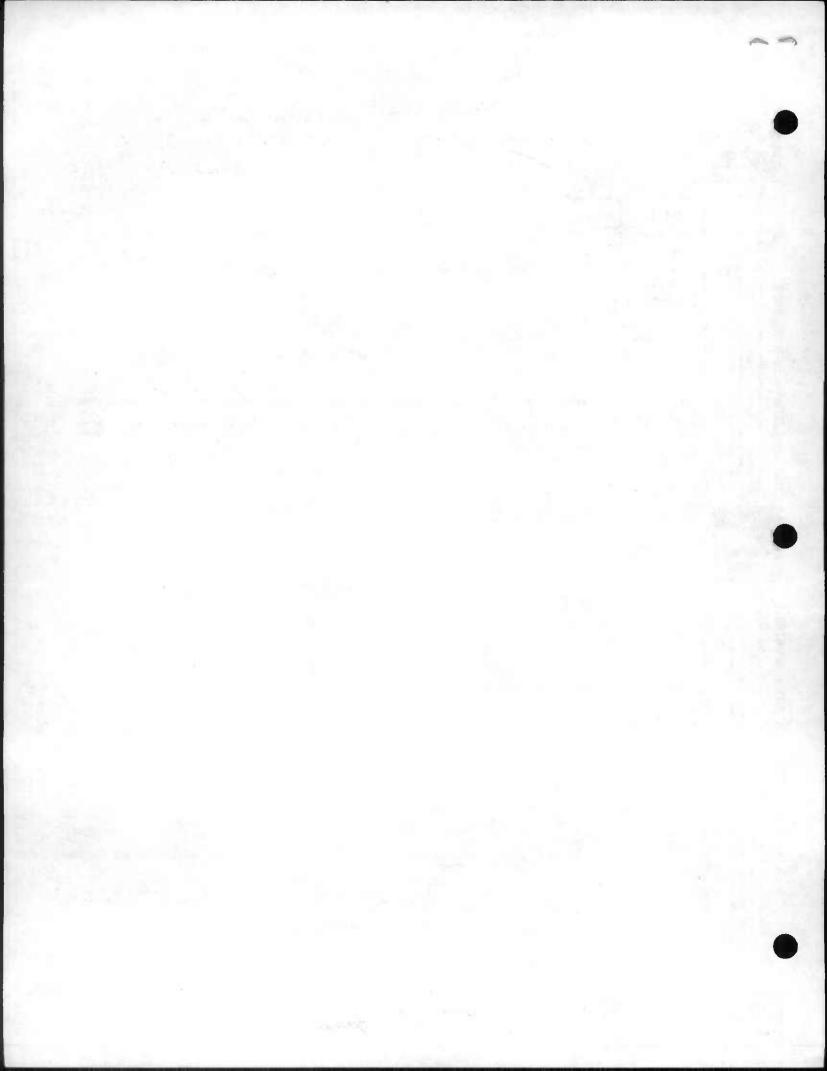
30. Nems and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician JAMES** CAUDILL JR JANYARY 27, 2000 2117 /Medical 4e Facility Neme (If not institution, give street end number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director 223-38-5557 September 23,1935 Virginia Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show 1 Yes 2X No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1114 Woodland Rd. 21801 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give natural, or Maryland 21215-0020 1 Yes 2X No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Delaware Dept. of permit. Pages 1 and 2 should be filed wit Department of Health and Mental hygiens Important: If item 27 ie marked other tha any Jujury or other traumetic event, the DRGB. Adult Probation Supervisor Corrections 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be James Kyle Caudill Sr. Agnes Sutherland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Joyce Caudill/Wife 1114 Woodland Rd., Salisbury, MD 21801 Baltimore, 20b. Piece of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Park 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 2/1/00 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine Colm physician and the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 20 No 3 Probably 4 Unknown been signed to should be det Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27, Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 Natural 1 Yes 2 No death. 2 Accident investigation Ne Hospital or Attanding 24 hours after death

Ne Funeral Director: / 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) DISIPPLE DISTRIBUTION DISTRIBUTION DISTRIBUTION DI STATE 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Badros M.D. BI3B EASTE SHORE DR. EASTERN 12 Badros 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 0 3 2000 Registrar

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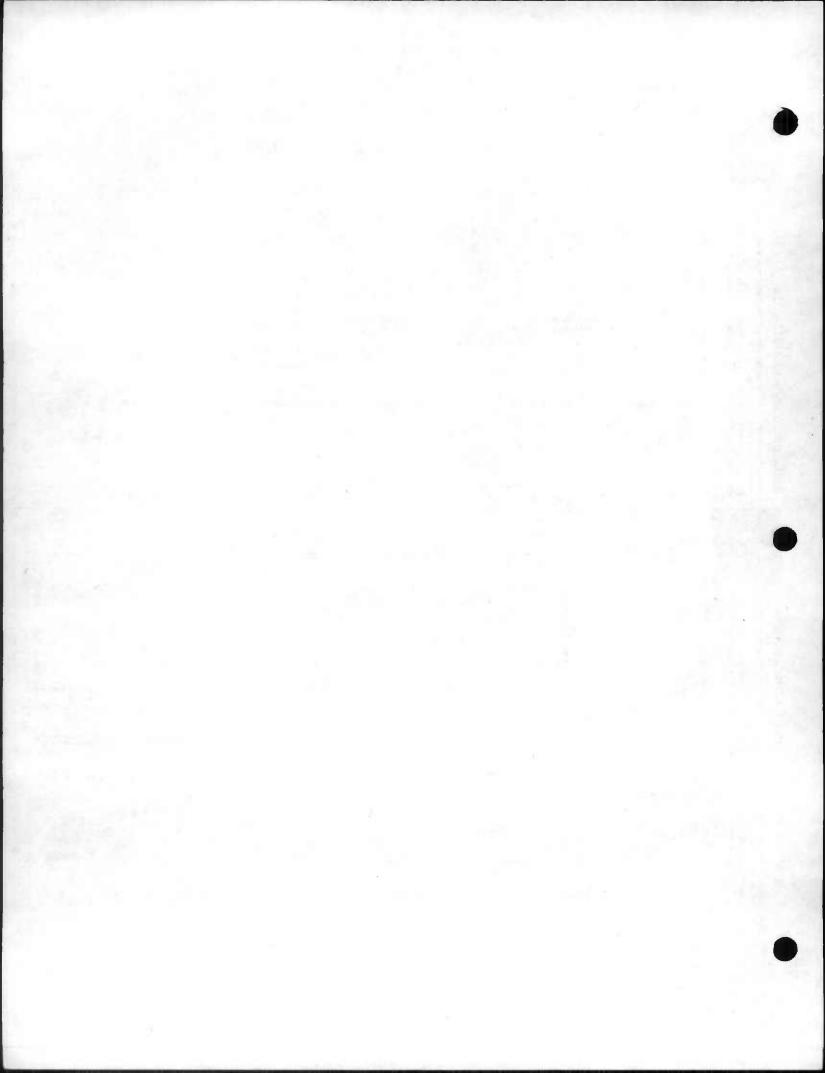
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DIVISION Of VITAL RECORD To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	rsician: To the best of m iner: On the basis of ext and mannar stated	amination and/or i	th occurred at the ti nvestigation, in my	ma, data and opinion, deal	d place, and th occurred	due to tha cau at the time, date	sa(s) and ma e and place, a	nnar as stated. and dua to the ca	ause(s)	
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06205 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 2000 2030 PM JAN NETTIE ROSE COLLINS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO ff Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) | If Under 1 Year 5. Social Security Number Birthplace (Stele or Foreign Country) **Funeral** 1□M 2K)F Months Deys Yrs. 221-56-3536 80 AUG 11, MARYLAND Director **Usual Residence of Decedent** 10a. Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2♥ No Directo DELAWARE SUSSEX MILLSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 3 BOX 233 D 19966 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Detes: 14. Rece - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Married than "natural", or 1 Yes 2X No Specify: Specify: WHITE 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Etemantery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be uepartment of Health and Mental important: If them 27 is marked or why Injury or other Ρ. Florence Mitchell Willie Shockley 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edward W. Collins 32029 Old Ocean City Road, Parsonsburg, MD 21849 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Millsboro Cemetery 1/27 Millsboro, Delaware 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility Watson Funeral Home, Inc. Richard Coloson 211 Washington Street, Millsboro, Delaware 19966 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Batween Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Cerebro-vasculir accident Examiner phone Vasculir disease Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last erosclerosis Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 □ Unknown 1 Yes 2 No by 24b. Wera autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed tery Disease 2 DNO 1 Yes 2 No 1 Yes To the Hospital or Atlanding Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) Hospitet: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 1 Weturat 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner steted. Medical 29e. Certifier (Check only one) 29b. Signature and title of certif 29c. License number 29d. Dete signed (Month, Day, Year) 1/24/00 D 36783 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury Jeffrey

Registrar

(lok)

31. Date filed (Month, Day, Year,

JAN 2 8 2000

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

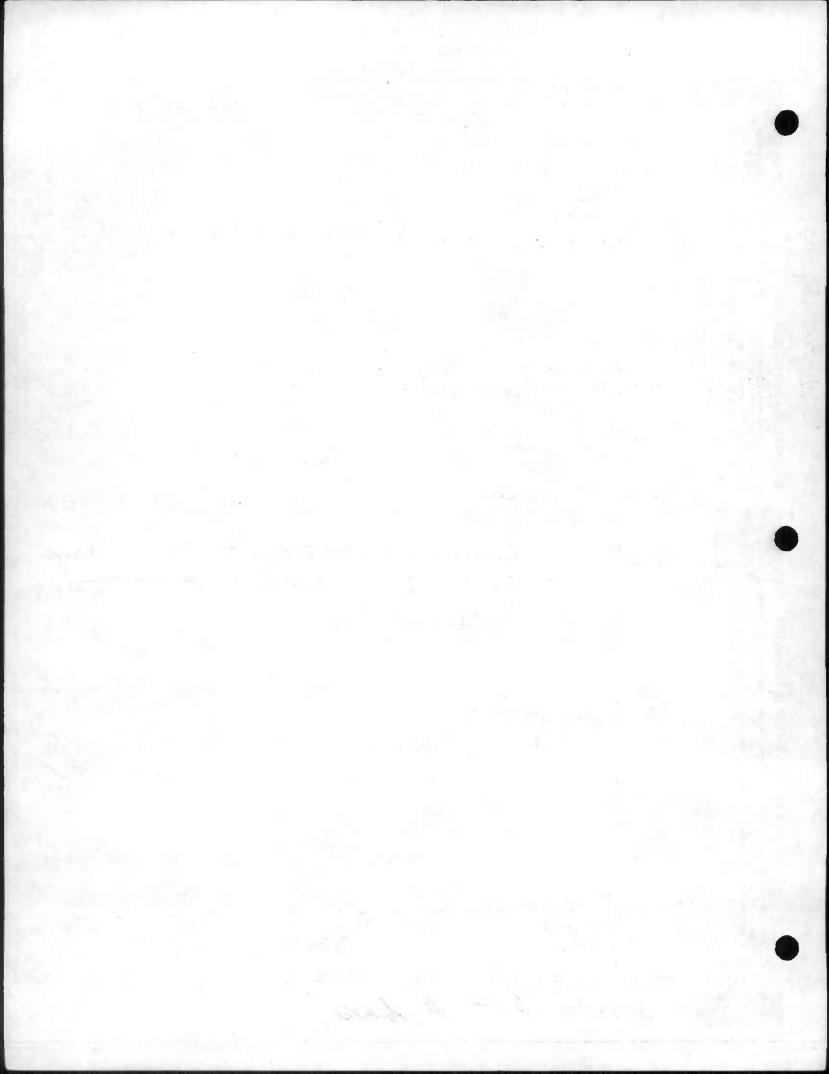
Records.

Division of Vital

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Ftherton

2. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BESSIE January 26,2000 5:30 AM CARSON /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** ATRIA SALISBURY SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 XF 196-20-1202 Yrs. Director 98 January 21,1902 Pennsylvania Usual Residence of Decedent the Menyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita 28a-f ahow mant be notified at Maryland Wicomico Fruitland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 206 Broken Arrow Trail 21826 USA death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yas 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: 3 Ø Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Department of Heelth and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Charles B. Eccleston Mathilda Butz 0 19a. Informent's Neme/Reletionship (Type, Print)
Eleanor M. Eccleston/Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 206 Broken Arrow Trail, Fruitland, MD 21826 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Crametion 3 ☐ Removel from Stete Salisbury Crematory 1/27/00 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility mo1051 Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.

A 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.

A 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Interval Between Onset and Death **Physician** 1/2 years /Medical Immediate Ceuse (Finel Carcinoma diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner ician and burial-transit or Attending Physician: The law requires that the deeth certificate be exacuted Sequentielly list conditions, if any, laeding to immadiete ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760. physician Physician/Medical the Due to (or es a consequence of): signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 28 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Wes an autopsy performed? Be Completed accident Cerebrovascular page 2 fibrilla. 1 Yes 2 No 1 ☐ Yas 2 ☐ No atria Division of Vital funeral director, 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Neture 5 Pending 1 Tyes 2 No 24 hours after death.

Funeral Director: A Invastigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) To the To the To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 100 Bur Street Salishing MD 2180 horles MO Jr Via

**DHMH 16 Rav 6/95** 

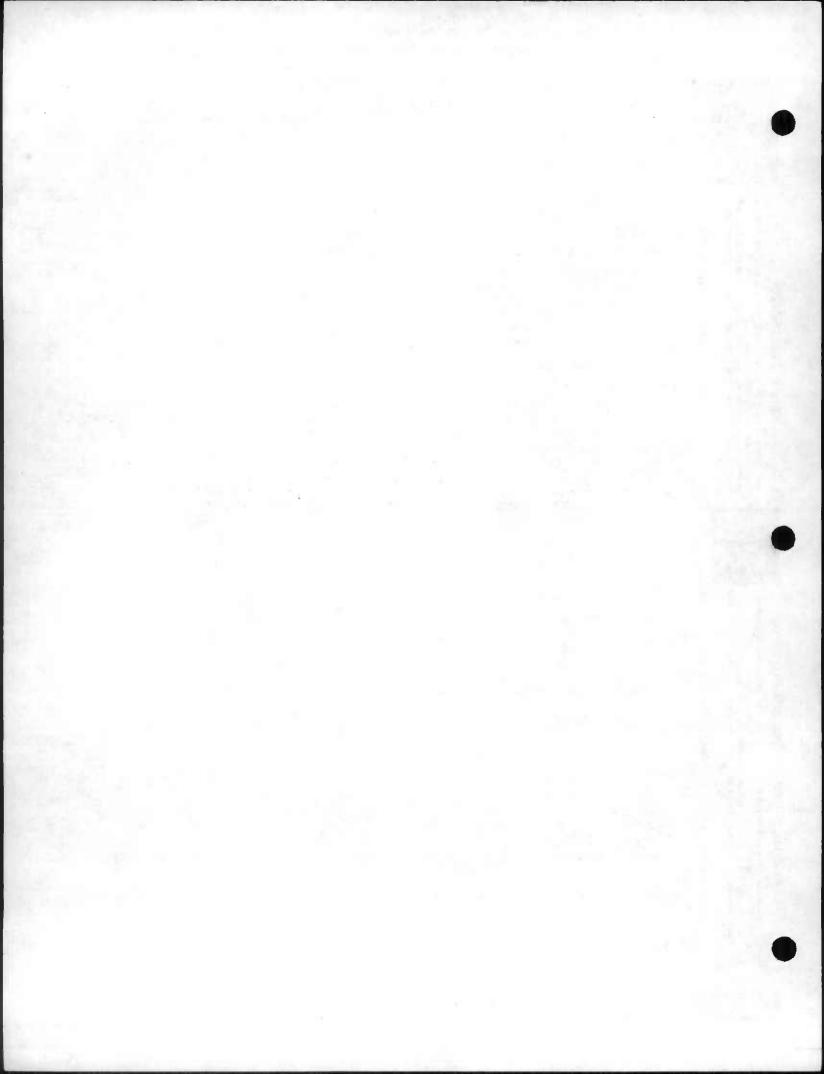
State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 7 2000

32. Registrer's Signeture

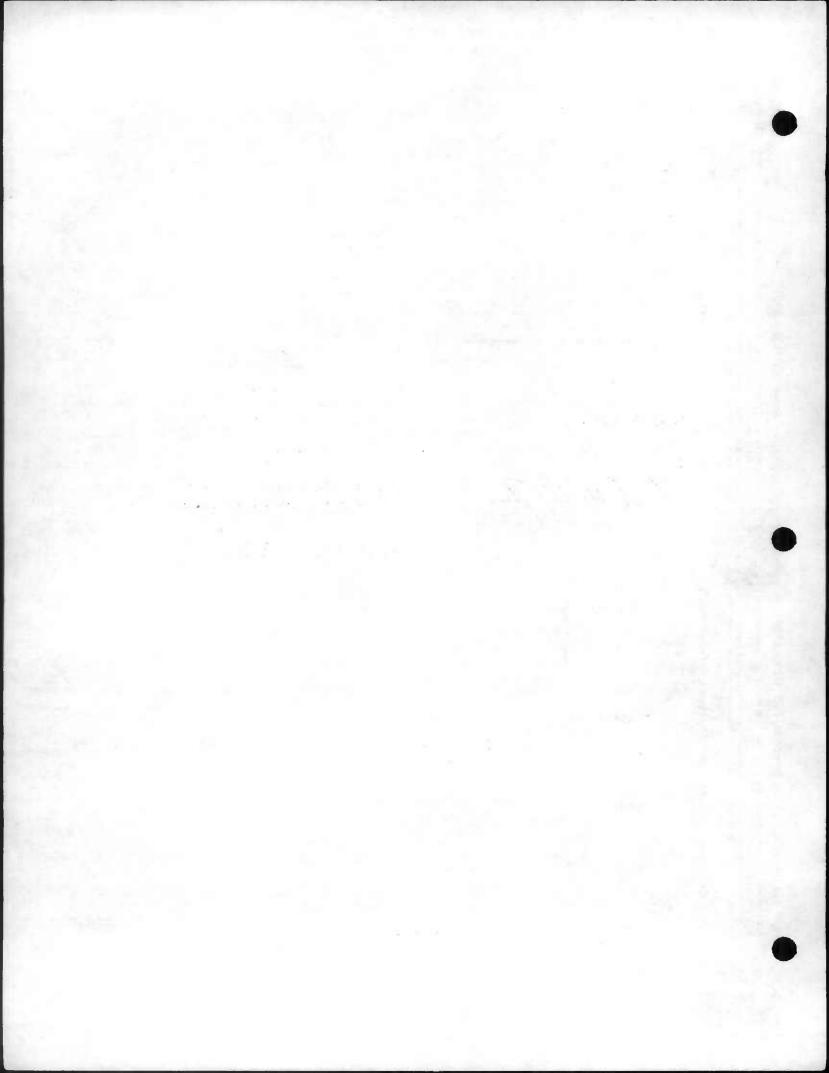


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 6, 2000 **Physician** 10:25PM Yvonne Coleman /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Corsica Hills Nursing Home Centreville If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year)
Dec. 26, 1911 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 20 F Belgium 545-48-6842 88 Director Usual Residence of Decedent the Maryland 10a. State 10b. County permit. Peges 1 and 2 ahould be filed within 72 hours effer death with the Marylan Department of Haalth and Mental Hygiena.
Important: if Item 27 is marked other than "natural", or itema 23s or 28s-f ahow with lighty or other treumatic event, the Medical Exercise must be notified an once. 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Postal Road 21619 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Ballet Dancer / Bookkeeper Self Employed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leopold Eisenstein Emma Jakob 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Coleman / Husband 1600 Postal Road Chester, MD. 21619 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation Center02/8 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Stevensville, MD. est Service Licera 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P. A. 106 Shamrock Road Chester, MD. 21619 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, our cause on each line. Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical eavs Examiner Examiner the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, physician Physician/Medical Due to (or as a consequence of): ettending p 88 ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. been signed by ahould be detac 1 Yes 2 10 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy performed? Completed page 2 certificate has 1 Yes 2 10 No 1 ☐ Yes 2 ₺ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one) 1 L/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai completely 29b. Signature and title of 9 29c. License numbe 29d. Date signed (Month, Day, Year) 100 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 2000 Registrar' Signature State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 06208

	CRUMBAUG  ve street end number)  Sepital  Sex  1 M 2 F  7. Age  12. Wes Decedent E Armed Forces? 1 M Yes, Give Yes, Give Yes, Give Tollege (1-4or 5-1)  Cumbaugh, Si  (Type, Print)  Daugh/Wife  Removel from Stete  in the caused	(In yrs. last b. 72  10c. City, Tow New Yor in U.S. o WW II 16e  20b. Please Commete Daws	Yrs.  13. Was fry 1 L  14. Deceder (Give kir life. Do. Meiling HC 7/2 of Disposit ery, crema son Ce 22. N	as Decedent Cores, specify Cores, specify Cores 2 North Nort	e e 2674  Of Hisper Libert, No. 5  Coupetion of during 18  140  140  140  150  160  170  180  180  180  180  180  180  18	anic Origin? (Specify:  In many most of work  Repai:  Mother's Nem  Elsie  New  Kender or Run  Kender of Run  K	ecity Yes or No. Rican, etc.)  rman e (First, Middle May Ri al Route Numb Creek, Date 6 2000	Dey RY 2 200 h 4c. County A1. rth ay, Year) 7, 1927  10g. Citizen of V US Description 14. Race Blace Specify 16b. Kind of Bi Teleption Maiden Sumen Ppeon Ppeon Pr. City or Town, WV 267 20c. Location Dawso	y of Deeth  legany  9. Birthplace (Stete or Foreign Country)  Maryland  10d. Inside City Limits 1 Yes 2 No  Whet Country?  SA 29 - American Indian, ck, White, etc.  Y:  White  usiness/Industry
cility Neme (III not institution, ging acred Heart Hotal Security Number 6. state 4-38-8914  Residence of Decedent 10b. County	pospital Sex 7. Age  To M 2 F 7. Age  To	(In yrs. last b. 72  10c. City, Tow New Yor in U.S. o WW II 16e  20b. Please Commete Daws	Yrs.  13. Was fry 1 L  14. Deceder (Give kir life. Do. Deceder)  D. Meiling HC 7: of Disposit ery, crema con Ce 22. N	Address (Streeter)	e e 2674  Of Hisper Libert, No. 5  Coupetion of during 18  140  140  140  150  160  170  180  180  180  180  180  180  18	Cumber: Under 24 Hrs. Hours Min.  43 anic Origin? (Specify: In many most of work e Repair. Mother's Neme Elsie New Herit Fecility eral Hotel	FEBRUA Cation of Deat  Land  B. Dete of Big (Month, De Dec. 2  ecity Yes or No Rican, etc.)  rman e (First, Middle May Ri al Route Numb Creek, Date Eeb. 6 2000	RY 2 200 h 4c. County A1. ith year) 7, 1927  10g. Citizen of V U3 b 14. Rac Blac Specify 16b. Kind of Bi Teleph , Maiden Surnen ppeon er, City or Town, WV 267 20c. Location -	9. Birthplace (Stete or Foreign Country)  9. Birthplace (Stete or Foreign Maryland  10d. Inside City Limits 1 Yes 2 No  Whet Country?  SA 20- American Indian, ck, White, etc.  Y:  White  usiness/Industry  hone Company  ne)  743  City or Town, State
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Acred Heart Ho late Security Number  6. 34—38—8914  Residence of Decedent late 10b. County  Mine treet and Number  HC 72, Box 14  Pritet Stetus  Never Married 2 Merried  Widowed 4 Divorced  15. Decedent's E (Specify only highest gr. nentery/Secondery (0-12)  Inter's Name (First, Middle, Last Cobert Edwin Cr Informent's Neme/Reletionship (12)  Delores Crumb  Buriel 2 Cremation 3 Companion 5 Other (Specify only highest gr. priter Crumb  Delores Crumb  Sert I. Enter the disease, or companion 5 Other (Specify only highest gr. Informent's Neme/Reletionship (12)  Delores Crumb  Sert I. Enter the disease, or companion of Funerel Service Lice  Part I. Enter the disease, or companion of the control of the contr	eral  7. Age  8. Armed Forces?  1. Armed Force	72  10c. City, Tow No.  No.  WW II  16a  20b. Plece cemete Daws	Yrs.  13. Was fry 1 L  14. Deceder (Give kir life. Do. Deceder)  D. Meiling HC 7: of Disposit ery, crema con Ce 22. N	Address (Streeter)	e e 2674  Of Hisper Libert, No. 5  Coupetion of during 18  140  140  140  150  160  170  180  180  180  180  180  180  18	Cumber: Under 24 Hrs. Hours Min.  43 anic Origin? (Specify: In many most of work e Repair. Mother's Neme Elsie New Herit Fecility eral Hotel	ecity Yes or No. Rican, etc.)  rman e (First, Middle May Ri al Route Numb Creek, Date 6 2000	A1.  th Pay, Year) 7, 1927  10g. Citizen of V US 14. Rac Bias Specify 16b. Kind of Bi Telepl , Maiden Surnen ppeon Per, City or Town, WV 267 20c. Location	Of Deeth   Deeth   Deep
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	as case referred to medical aminer?  Yes 21X No enner of Death Neturel   Suicide   Homicide   Could not be determined.  Servicide   Could not be determined.  Certifier   11X Certifying Placek only one)   Medical Example one)   Could not be determined.	Other eignificant conditions contributing to death but as case referred to medical aminer?  Yes 2 No Hospitel: 18 Inpatier  Accident Suicide Investigation Accident Suicide Homicide Suicide Homicide Suicide Homicide Suicide Homicide Suicide Homicide Suicide Suicide Homicide Suicide Homicide Suicide Suicide Homicide Suicide Suicide Homicide Suicide Homicide Suicide Suicide Suicide Homicide Suicide Suicide Suicide Homicide Suicide Su	Other eignificant conditions contributing to death but not resulting  as case referred to medical aminer?  Yes 2 No  Inpatient 2 EP/O  Inp	Other eignificant conditions contributing to death but not resulting in the und  as case referred to medical aminer?  Yes 2 No  Hospitel: 1 Inpatient 2 EP/Outpatient  Neturel Investigation 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury  Neturel Investigation 28e. Place of Injury - At home, ferm, streed building, etc. (Specify)  Pertitier Check only 2 Medical Examiner: On the basis of examinetion end/or investigation and menner steled.  Signature and title of certifier  A A A A A A B A A A A A B A A A A A B A A A A A B A A A A A B A A A A A A B A A A A A A B A A A A A B A A A A A B A A A A A A B A A A A A A B A A A A A A B A A A A A B A A A A A B A A A A A A B A A A A A B A A A A A A B A A A A A B A A A A A B A A A A A B A A A A A B A A A A A B A A A A A B A A A A A B A A A A A A B A A A A A B A A A A A B A A A A A B A A A A A A B A A A A A B A A A A A A B A A A A A A B A A A A A A B A A A A A A B A A A A A A B A	Other eignificant conditions contributing to death but not resulting in the underlying cause as case referred to medical aminer?    Yes 2   No	Other eignificant conditions contributing to death but not resulting in the underlying cause given in the deciral aminer?    Accepted to medical aminer?   Hospitel: 1 Inpatient 2   ER/Outpatient 3   DOA   Other: 28a. Deteof Injury   28b. Time of Injury   28c. Injury et Work?   1   Yes   28c. Injury et Work?   1   Yes   28c. Plece of Injury - At home, ferm, street, fectory, office   28e. Plece of Injury - At home, ferm, street, fectory, office	Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Cachex   All   Accident   Accident   Suicide   Accident   Accident   Accident   Accident   Accident   Suicide   Accident   Accident	Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Cachery	Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use of a condition of the condition of the underlying cause given in Pert I.   23b. Did tobacco use of a condition of the underlying cause given in Pert I.   24a. Was an autopsy performed?   1   Yes   2   No     24a. Was an autopsy performed?   24b. Describe how injury occurrence injury at work?   1   1   1   1   1   1   1   1   1

DHMH 16 Rev 6/95

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

7. Age (In yrs. last birthday)

93 Yrs

10c. City, Town or Location

Frederick

State of Maryland / Department of Health and Mental Hygiene

10f. Zip Code

21701

Certificate of Death 2. Date of Death 3. Time of Death 2000 MARGARET ELLEN DAILEY February 0120 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) | Fredericon | Fre

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10a. State

Maryland

10e. Sireel and Number

Directo

212-38-9364

Usual Residence of Decedent

College View Nursing Center

Frederick

10b. County

700 Toll House Avenue

1□ M 2 F

**Funeral** Director

with the Marylenc 28a-f ahow the Medical Examiner must be notified at 8 234

parmit. Pages 1 and 2 should be filed within 72 hours after death very process. The state of Health and Mental Hygiene. Important: if than 27 is marked other than "natural", or ferme 23a any Injury or other traumatic avant, the Heages Experience once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 2 No If Yes, Give Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Stalus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Nannie Croft Daniel B. Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1206 Beechwood Drive, Frederick, Maryland 21701 Robert E. Dailey Jr. (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Stata Mount Olivet Cemetery 4 ☐ Donation \_5 ☐ Other (Specify) 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 tha death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or es e consequence of): Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as e consequence of): Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by of Vital Records, by page 2 should be edical Certification: To Be Completed After this certificate has Corener or Attanding Physician: after death.

Director: After this certific d in by the funerel director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Division 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Data signad (Month, Day, Year) 29b. Signature and tillia 29c. Licansa number 22/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

FEB 0 9 2000

31. Date filed (Month, Day, Year)

Own Home 20c. Location - City or Town, State 2/14/00 Frederick, Maryland 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 TYAS 20 No 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

00

Birthplace (State or Foreign Country)

10g. Citizan of What Country?

U.S.A.

Specify:

14. Race - American Indian, Black, Whita, etc.

White

10d. Inside City Limits

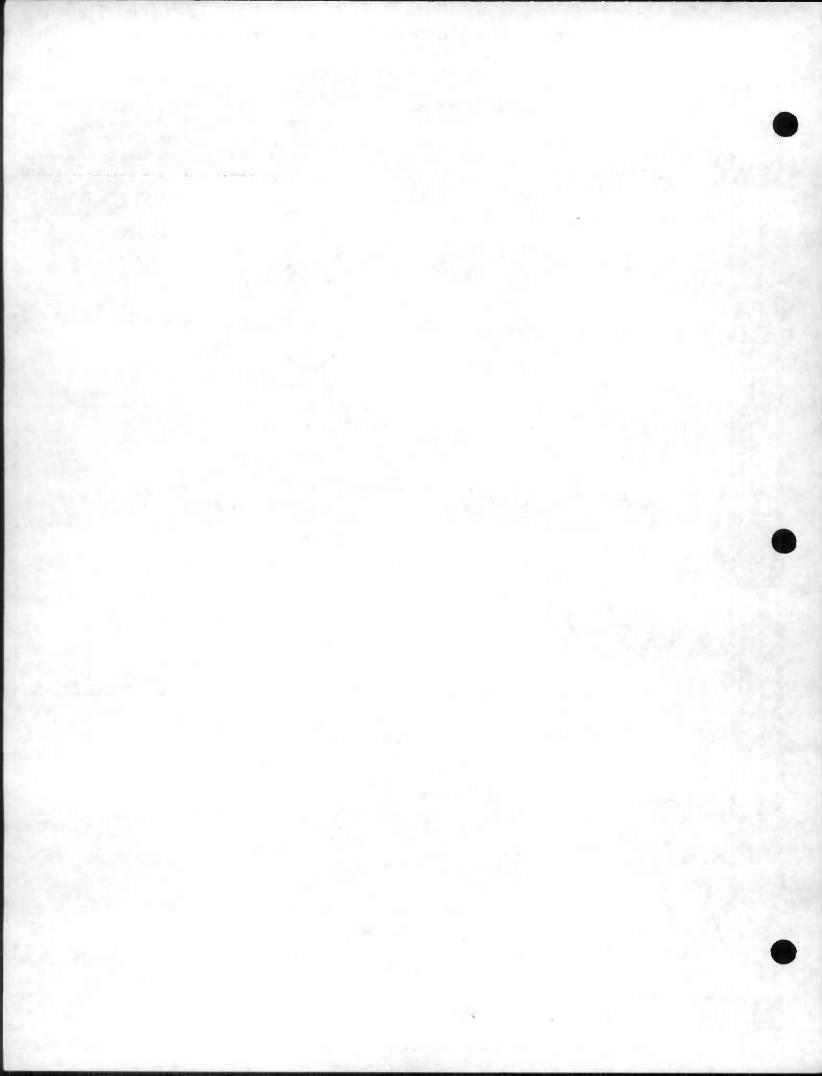
1 Yas 2 □ No

Registrar

State

Lloyd E. Halvorson, MD 1475 Taney Avenue, Frederick, Maryland 21701

32. Registrer's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Year 4:02 pm February 2000 homas Dawson 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Bayview Medical Baltimore HONKINS (enter Baltimore Johns Birthplace (Stete or Foreign (Country) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Days 1₩ M 2□ F 19, Pennsylvania 68 July 203-24-2868 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 □ No Harford Aberdeen 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 647 Brenda Lane 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Yes 2 No Yas, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 20 yr. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas T. Dawson, Sr. Eva Hawks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Jean M. Dawson (Spouse) 647 Brenda Lane, Aberdeen, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 2/11/00 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused he death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel diseasa or condition rasulting in death) cancer Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): neumonia Due to (or as a consequence of). irator 3 week 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? 26. Placa of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

by

Completed

Be

**Funeral** 

Director

28s-4

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Hygiene.

nt of Health a : If them 27 is or other tra

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed the signed by the attending p page 2 should or Attending Physician: this

Examiner Physician/Medical Completed by funeral After

Medical Certification: To Be death. 24 hours after deat Funeral Director: filled in by

Division of Vital Records, P.O. Box 68760

Hospital within 2 To the F 4

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

1 Yas 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Date signed (Month, Day, Year)

1 Yes 2 No

5 Pending investigation

6 Could not be datamined

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28a. Placa of Injury · At homa, farm, straat, factory, office building, atc. (Specify)

4 5

#### Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 1, 2000 **Physician** Douglas 10:40 P.M. Corrie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Glade Valley Nursing Home Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Year 1910 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2QF 148-22-9999 89 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits flares 23a or 28a-f show Frederick Maryland Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6733-C South Clifton Road 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 'natural', or 1 ☐ Yes 2 No Specify: White Specify: 3Ñ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) Coilege (1-4or 5+) County Heart Association Executive Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Ihm 27 is marked o any Injury or other traumatic eve Cornelius Vande Stadt Hendricka deBrauyn 19a. Informant's Name/Relationship (Type, Print) Jean Douglas Cadle/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10635 Harney Road, Emmitsburg, Maryland 21727 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition \*\*District 2 Gremation 3 Removal from State Mt. Olivet Cemetery Feb. 7, 2000 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home M00021 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To After thi funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNeture 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

requires that the death certificate be executed P.O. Records. Division of Vital or Attending Physician: s after dea. To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

altimore, Maryland 21215-0020

Box 68760.

be filed within

Pages 1 and 2 should

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7, Prelence 14/21701

32. Registrans Signature

State Registrar

4 Homicide

(Check only one)

31. Date filed (Month, Day (Year)

FEB 0 3 2000

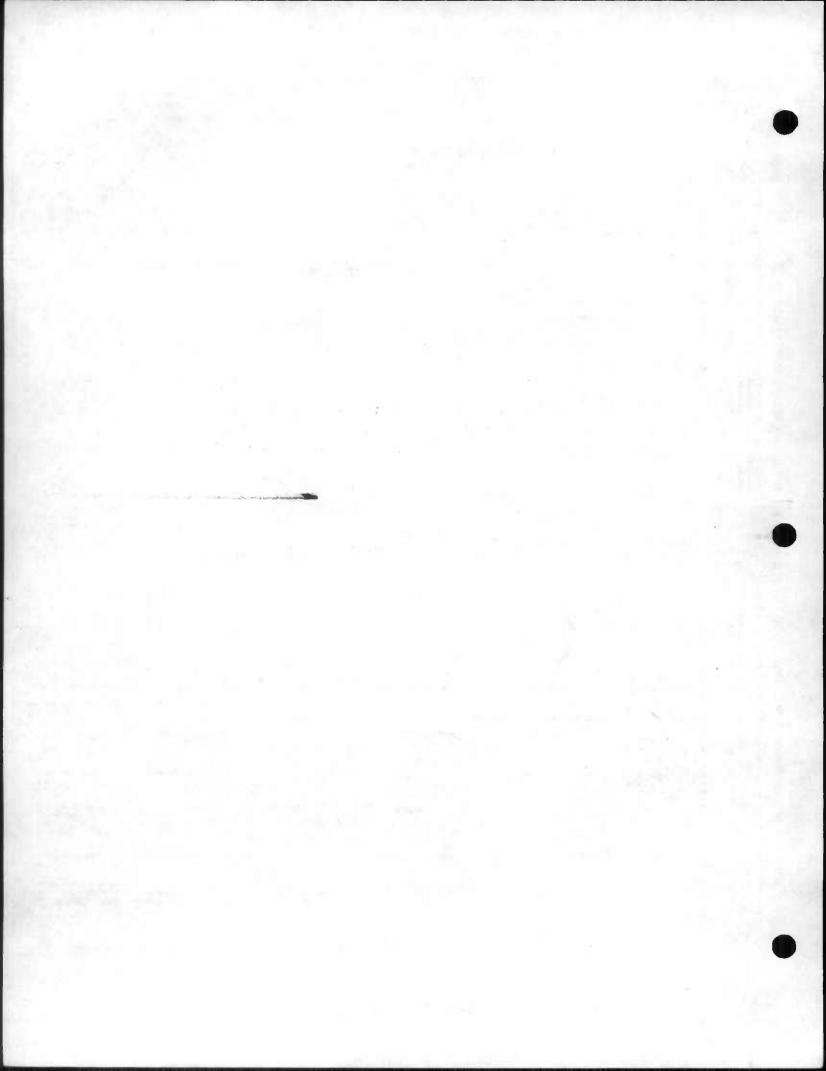
29e. Certifier

**DHMH 16 Rev 6/95** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

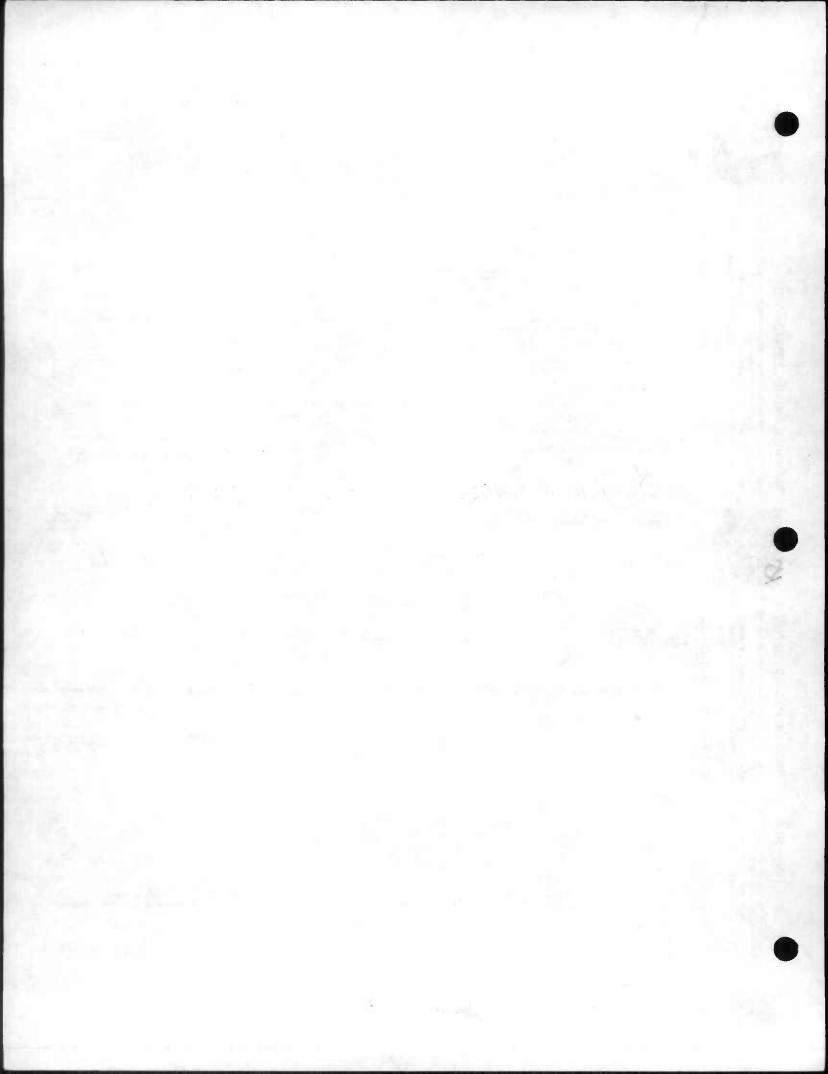
29d. Date signed (Month, Day, Year)



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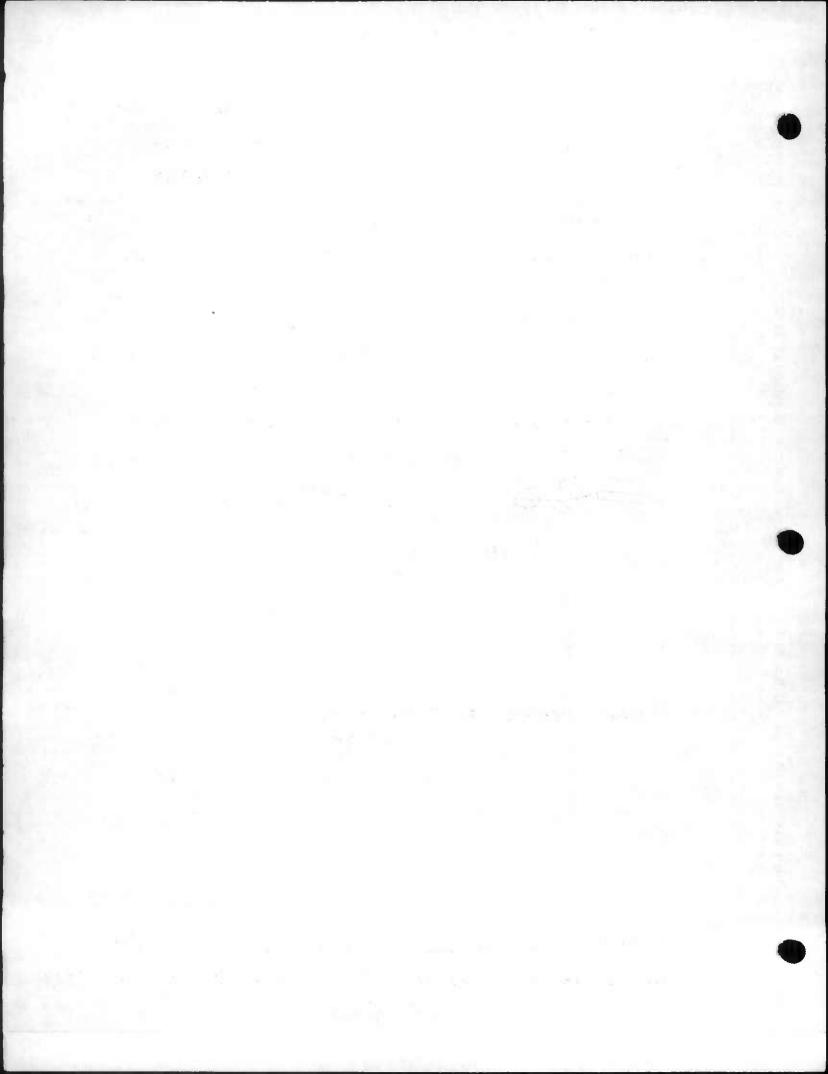
State of Maryland / Department of Health and Mental Hygiene 0 0 62 12

					Cert	ificate of	Death	,	Reg. No.	1	0616	
	Dhuaisian	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	eath Day	Year	3. Time of Death	
	Physician /Medical	DONAL	D	DAWSO	ON			FEBRU	ARY 2,	2000	1:29 AM	
	Examiner	4a Facility Name (If not institution						or Location of Deat				
	*	Frederick Memo			4.44.4. 1	If Under 1 Yea	Frederi			deric		
	Funeral Director	5. Social Security Number  195-12-2471  Usual Residence of Decedent	6. Sex 10X M 2□ F	ge (In yrs. last	Yrs.	Months Days		lin. 8. Data of Bi (Month, Di Sept 6	ay, Year)	9. Birthol Count Bruns	lace (State or Foreign try) SWICK, MD	
	New Year	10a. State 10b. County		10c. City, To	own or Loca	ation				10	Od. Inside City Limits	
	death with the Maryland ms 23a or 28s-f show Linuis be notified at	MD Frede	rick	Frede	erick						1 ☐ Yes 2 <b>XX</b> NO	
	or 28e-f a per 28e-f a per 28e-f a	10e. Street and Number				10f. Zip Code			10g. Citizen of V	/hat Coun	itry?	
	23a 19	6409A Weatherb	y Court			21701			USA			
21215-0020	ar, or he by Fur	3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 [X] Yes 2 [If Yes, Give Year or Dates:	?		as Decedent of Yes, specify Cu Yes 2 💢 No		(Specify Yes or No Jerto Rican, etc.)	Specify	e - America k, White, d		
5-0	72 hc	15. Decedent (Specify only highes		10	6a. Decede	nt's Usual Occi	pation a during most of t	working	16b. Kind of Bu			
21	un de	Elementary/Secondary (0-12)	College (1-4or		lifa. DO	O NOT use retir	ed)		Shelly!			
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and	12 should be filled v h and Mental Hygle F is marked other t traumatic event, the TO Be CO	17. Father's Name (First, Middle, I						Nama (First, Middle		a)		
2	A Mend					111 (0)		Mae Gram		O	0.71	
Maryland	d 2 al th an traur	19a. Informant's Name/Relationsh Pamela J. Keel						d Road,				
	is 1 and 2 abould be filed of Haaith and Mental tyrg ham 27 is marked other other traumatic event, TO Be C	20a. Method of Disposition	ing, badgire	20b. Place	of Disposit	tion (Name of		Data	20c. Location -			
Baltimore	permit. Pages Depertment of Important: If it any injury or and	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc	ecify)		0live	t Cemet	ery	2/6/2000	Lovetts	ville	e, VA	
Bal	Depermination of the control of the		rilliants, by	llan	Jol 100	Name and Add hn T. W O Peter	illiams sville R	Funeral Road, Bru	Home nswick,	MD 21	1716	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	d the death. D	o not entar	the mode of dy	ring, such as card	diac or respiratory a	rrest,		Approximate Interval Between	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition	ac	ite	Can	word	vy ed	lema		1	Onset and Death	
		resulting in death)		Dua to (or as		ence of):		dise		1		
	hed he		<b>b</b>	overe	zuy	ant	ery	dise	2	-		
68760,	physician and a the buriet transit substitution of the buriet transit selection of the buriet of the b	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
Box 687	5 00	resulting in death) Last	d	Due to (or as	a conseque	ence of):						
m	d for	Part II Other eignificant condition	e contribution to death	entributing to death but not resulting in the underlying cause given in Part I.					23b. Did lobacco use contribute to the cause of death?			
P.0	that the death cardidate by the attendir detached for use	Chronic					din.		Tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown			
Records,	The law requires that the death certest has been signed by the attending page 2 should be datached for use Completed by Physician/N								24a. Was an autopsy performed?		ere autopsy findings allable prior to mpletion of cause death?	
<u>R</u>	The law page 2 s							10	Yes 2 No	10	Yes 2□ No	
Vital	yalclan: The law director, pega 2 s director, pega 2 s To Be Compil	25. Was case refarred to medical examiner?						Death (Check only	one)			
of	2 2 2	1 Yes 2⊠No		ient 2 DER	Outpatient (	3LI DON		g Home 5 ☐ Ras			y)	
Division o	Attending Physician: Ir death. Setor: After this certific by the funeral director, lification: To Be (	27. Manner of Death  1 Naturat 5 Pending 2 Accident investig	ation	ay Year) 28t	b. Time of Injury	28c. Inj W M 1[	ury at ork? Yes 2 No	28d. Describe	how injury occurr	ed		
DIVI	tal or Awanding P is after death. Is Director After ted in by the funeral Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 288. Place of in	ijury - At home, tc. <i>(Specify)</i>	, farm, stree	et, factory, office			Street and Numb wn, State)	er or Rura	al Route Number,	
	n 24 hound no 24 hound no Funer pletsty fill edical	29a. Certifier 12 Certifying (Check only one) 12 Medical E	Physician: To the best xaminer: On the basis of and manner s	axamination	ige, death o and/or inve	occurred at tha stigation, in my	tima, data and pla opinion, daath o	ace, and dua to the ccurred at the time	cause(s) and ma data and place, a	nner as st and due to	tated. the cause(s)	
	To the Com	29b. Signature and title of contiller					nse number		29d. Date signed	1 (Month, i	Day, Year)	
		1 K. 8	evale			D 2	1648		2 2	00		
		30. Name and address of person v	who completed cause of BARAK	death (Item 23	a) (Type, Pr	rint) of the	5 40	eet F	velevi	ile.	MD 21701	
Г	State Registrar	31. Date filed (Month, Day, Year)		rags Signature	~	b	low V	/				



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nem	e (First, Middle, Las	st)					2. Dete of De Month	eth Dey	Yeer 3.	Time of Deel
Physic /Medi		Louis D	evinse						Feb			350 AM
Exami		4a. Fecility Neme (f.	f not institution, give	e street end number	or)			4b. City, Town, o	r Location of Deet	h 4c. County	of Deeth	
			w Health					Salisbu	ıry	Wicon	nico	
Funerai Director	_	5. Sociel Security N 261-85-44 Usuel Residence of	34	YTM OF E	Age (In yrs. le 65		If Under 1 Year Months Deys			th by, Yeer) , 1934	9. Birthplace Country) Hai	(State or For
Mo III		10e. State	10b. County		10c. City,	Town or Loca	ation			10d. In:		nside City Lln
28a-f ahow	to	MD	Wicomio	co	S	Salisbu	ry			ty⊡ Yes 2□		
or 28s	irec	10e. Street end Nur	nber				10f. Zip Code			10g. Citizen of Whet Country?		
23a c	a	Watervie	w Health	care		21801				U.S.		
ene. than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at	MD Wicom  10e. Street end Number  Waterview Healt  11. Maritel Status unknown  1 Never Merried 2 Married  3 Widowed 4 Divorcad		ed 2 Married	12. Was Decedent Ever In U.S. Armed Forces?  1			es Decedent of Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	Blec	14. Race - American Indien, Bleck, White, etc. Specify: Black	
nd Mental Hygiena. markad other than "natural", or imatic event, the Medical Every	Completed	Elementery/Seco		lucation de com <i>pleted)</i> Cotlege (1-4or	16a. Decedent's Usuel Occupation (Give kind of work done during most of wo life. DO NOT use retired)  unknown				usiness/industry			
H S		17. Fether's Neme (					CI DI II	1	eme (First, Middle			
and Mental	To Be	unk	nown					un	known			
mer umet	-	19e. Informent's Na		Type, Print)		19b. Mailing	Address (Stree		Rural Route Numb	er, City or Town,	Stete, Zip Cod	ie)
		Mashelle	Purnell	casework	er	Wicom	ico Cou	nty DSS.	Salisbu	rv. MD 2	1801	
Department of Haalth important: If Item 27 any Injury or other to once.				Removel from State	e cei	aca of Disposit metery, creme	tion (Name of tory or other ple	ace)	Dete 2/12/00	20c. Location -	City or Town,	
Departments any inju		21. Signature of Fu	peral Bervine Licon	too /	1	22. 1	Name end Addr	ess of Fecility			21	
0 = 2 8		23e. Pert1. Enter ff shock, or hear	79	1	_	Le	wis N.	Watson F	uneral H	ome	1	
	resulting in deeth)					TUMOR						
n and iel-trensit	Examine	Sequentially list cor if eny, leeding to Im	nditions, mediete	b. —————	Due to (or	es e conseque	enca of):					
nding physician and use as the buriel-trensit	n/Medical Examiner	Sequentially list cor if eny, leeding to Im- cause. Enter Unde Ceuse (Disease or- thet Initieted events resulting in deeth) L		b. ————————————————————————————————————	Due to (or	es e conseque	enca of):					
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by the attending eched for use a	Physician/Medical	resulting in deeth) L	est	b. — C. — d. — ontributing to death	Due to (or e	es e conseque es e conseque es e conseque	anca of): anca of): anca of): anca of):	ven in Pert I.		tobacco uee con Yes 2□ No	ntribute to the	-
is been signed by the attending 2 should be deteched for use a	by Physician/Medical	resulting in deeth) L	est	b. ————————————————————————————————————	Due to (or e	es e conseque es e conseque es e conseque	anca of): anca of): anca of): anca of):	ven in Pert I.	1 □		3 ☐ Probably  24b. Were e	outopsy finding prior fo
ete has been signed by the attending page 2 should be deteched for use a	Physician/Medical	resulting in deeth) L	est	b. — C. — d. — ontributing to death	Due to (or e	es e conseque es e conseque es e conseque	anca of): anca of): anca of): anca of):	ven in Pert I.	1 □	Yes 2□ No en eutopsy enmed?	3 Probably  24b. Were e eveilable comple	outopsy findiale prior fo
ete has been signed by the attending page 2 should be deteched for use a	Be Completed by Physician/Medical	resulting in deeth) L	cent conditione co	b. — c. — d. — ontributing to death	Due to (or e	es e conseque es e conseque es e conseque	enca of): enca of): enta of): erlying cause gi	9 - 26. Plece of D	1 🗆 24e. Wes perfo	Yes 2□ No en eutopsy med?  Yes 2□ No	3 Probably  24b. Were e eveilabl comple of death	outopsy findi le prior fo stion of caus h?
is certificete has been signed by the attending director, page 2 should be deteched for use a	To Be Completed by Physician/Medical	Pert II. Other significations of the state o	cent conditione co	b	Due to (or e	es e conseque es e conseque es e conseque ting in the und	enca of):  enca of):  errying cause gi  CULA  1 SQUA  3 DOA  OT  28c. Inju Wc	26. Piece of Diher:	24e. Wes perfo	Yes 2□ No en eutopsy med?  Yes 2□ No	3 Probably  24b. Were e eveilable comple of death  1 Yes	outopsy findi le prior fo stion of caus h?
eath. or: After this certificete has been signed by the attending the funeral director, page 2 should be deteched for use a	o Be Completed by Physician/Medical	Pert II. Other significations of the second	cent conditions co	b. —  c. —  d. —  pontributing to death  MO FT C  Hospital: 1 ☐ Inpat  28e. Dete of Inf  (Month, D.)  28e. Place of Ir	Due to (or e	es e conseque es e conseque ting in the und  Do UU  R/Outpetient 28b. Time of Injury	enca of):  enca of):  errying cause gi  CULA  1 SQUA  3 DOA  OT  28c. Inju Wc	26. Piece of Diher: 4 Nursing	24e. Wes perfo	Yes 2□ No  en eutopsy med?  Yes 2□No  one)  denca 6 □Othe how injury occurr  Street end Numbe	3 Probably  24b. Were e eveilable comple of death  1 Yes  er (Specify)	putopsy finding le prior for stion of causin?
4 hours after death.  Funaral Director: After this certificete has been signed by the attending tay filled in by the funeral director, page 2 should be deteched for use a	To Be Completed by Physician/Medical	Pert II. Other algniff  25. Wes case referrexaminer? 1   Yes 2    27. Menger of Deett   Naturel   2   Accident   3   Suicide   4   Homicide	ed to medical No  Pending investigation  Could not be determined	b. —  c. —  d. —  pontributing to death  MO FT C  Hospital: 1 ☐ Inpat  28e. Dete of Inf  (Month, D.)  28e. Place of Ir	Due to (or examination of examination of the following states of the following	es e conseque es e conseque es e conseque ting in the und  CR/Outpetient 28b. Time of Injury ne, ferm, stree	anca of):   26. Plece of Diher: 4 Nursing ry et rk?  ] Yes 2 No	24e. Wes performed to the set of the control of the	Yes 2 No en eutopsymmed?  Yes 2 No one) denca 6 Othe how injury occurr  Street end Number wn, Stete)	3 Probably  24b. Were e eveilable comple of death  1 Yes  er (Specify)  ed	ute Number,	
death. ctor: After this certificete has been signed by the attending y the funeral director, page 2 should be deteched for use a	Certification: To Be Completed by Physician/Medical	25. Wes case referrescaminer?  1 Yes 2 2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only one)	ed to medical  So Pending investigation 6 Could not be determined	b. —  c. —  d. —  where the second of the se	Due to (or examination of examination of the following stated.	es e conseque es e conseque es e conseque ting in the und  CR/Outpetient 28b. Time of Injury ne, ferm, stree	anca of):   26. Plece of Diher: 4 Nursing invetrik?  Yes 2 No	24e. Wes performed to the set of the control of the	Yes 2 No en eutopsymmed?  Yes 2 No one) denca 6 Othe how injury occurr  Street and Number wn, Stete)  ceuse(s) end medete end place, s	3 Probably  24b. Were e eveilable comple of death  1 Yes  er (Specify)  ed  er or Rurel Rou  nner es steted and due to the	uttopsy finding le prior fo stion of cause h?  s 2 No	
4 hours after death.  Funaral Director: After this certificete has been signed by the attending tay filled in by the funeral director, page 2 should be deteched for use a	edical Certification: To Be Completed by Physician/Medical	25. Wes case referrescentified events resulting in deeth) L  25. Wes case referrescentified events and the second	ed to medical  So Pending investigation 6 Could not be determined	b. —  c. —  d. —  where the second of the se	Due to (or examination of examination of the following stated.	es e conseque es e conseque es e conseque ting in the und  CR/Outpetient 28b. Time of Injury ne, ferm, stree	anca of):   26. Plece of Diher: 4 Nursing invetrik?  Yes 2 No	24e. Wes performed to the course of the time,	Yes 2 No  en eutopsy med?  Yes 2 No  one)  dence 6 Othe how injury occurr  Street end Number wn, Stete)  ceuse(s) end medete end piece, e	3 Probably  24b. Were e eveilable comple of death  1 Yes  er (Specify)  ed  er or Rurel Rou  nner es steted and due to the	uttopsy finding le prior fo stion of cause h?  s 2 No	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death February 8, 2000 Dalton Sr Leo 4:40 PM 4a Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury, MD Wicomico

If Under 1 Year

10f. Zip Code

Months

Days

21842

1 Yes 2 No Specify:

7. Age (In yrs. last birthday)

10c. City, Town or Location

Ocean City

81

12. Wes Decedent Evar in U,S. Armed Forces?

I X Yas 2 No Army

Year or Detes: WW II

If Under 24 Hrs.

Hours

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.)

8. Dete of Birth (Month, Day, Year)

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

April 10,1918 Washington, DC

10g. Citizen of What Country?

14. Race - American Indien, Bleck, White, etc.

White

USA

Specify:

**Physician** /Medical Examiner

Arthur

5. Social Security Number

579-03-9165

10a State

Maryland

11 Marital Status

10e Street and Number

Director

Funeral

þ

Usual Residence of Decedent

10b. County

158 Old Wharf Rd.

1 Naver Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Salisbury Center: Genesis ElderCare

Worcester

1**X**0 M 2□ F

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

2000

M.D.

32. Registrar's Signeture

Michael R. Atkins,

31. Dete filed (Month, Day, Year) FEB 10

**Funeral** Director

deeth with the Maryland Show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiene. is marked other . Pages 1 and 2 should be fill ment of Health and Mentel Hant: if item 27 is marked oth lury or other traumatic even Department of important: if eny injury or

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Division of Vital Records.

Physician /Medical Examiner

The law requires that the death certificate be executed the burial-tran has page 2 certificate or Attending Physician: this funeral After

Be Completed by Physician/Medical Examiner Medical Certification: To s after death. completely filled in by Hospital 6 To the To the T

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Policeman Law Enforcement 12 17. Fethar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be James Dalton Mary Fitzgibbon 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 158 Old Wharf Rd., Ocean City, MD 21842 Rita L. Dalton/Wife 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/10/00 Salisbury, Md Salisbury Crematory 22. Name end Address of Fecility
Holloway Funeral Home Professional Association 21. Signeture of Funerel Service Licensee Keeth 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting In deeth) enes Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initieted events resulting in death) Lest Due to (or as a consequence of): Dua to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown METASTATIC 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 2 No Copy 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

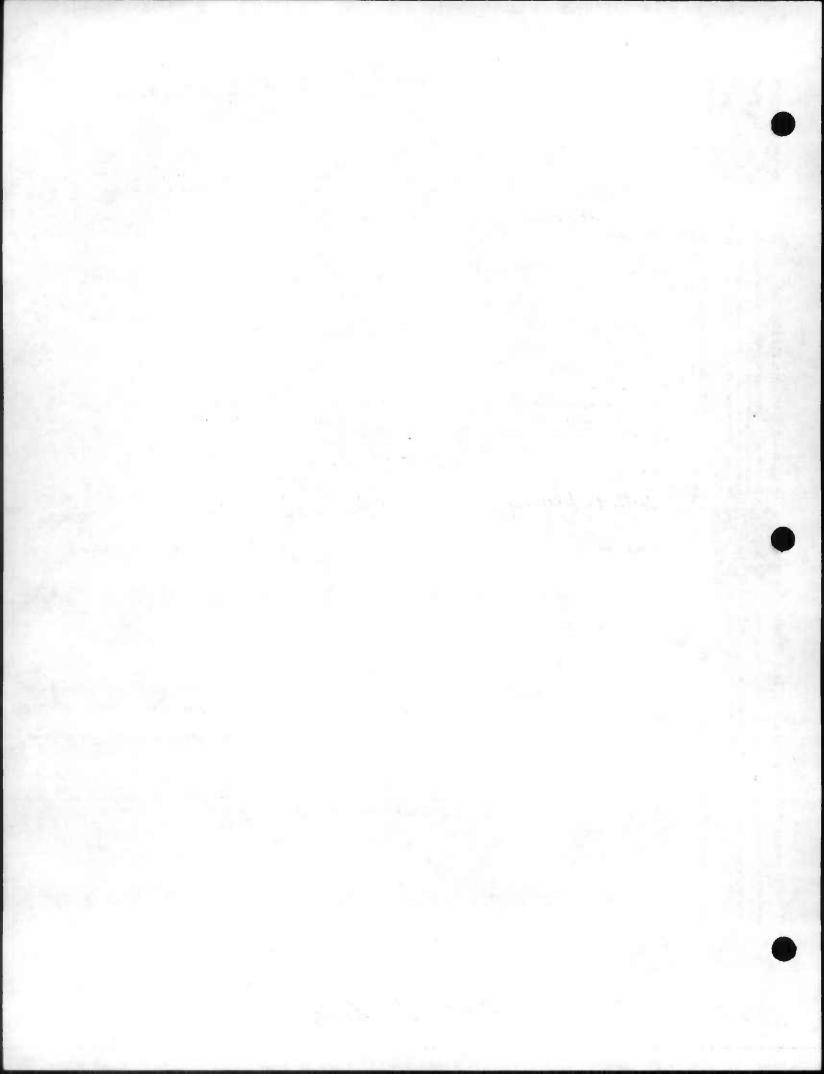
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 00

10

State

Registrar

1104 Healthway Dr., Salisbury, MD



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MICHAEL E. DEAL. February 200 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hunder 24 Hrs. 8. Date of Birth Hours Min. MAY 19, 1956 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Davs SALTSBURY 15 M 2□ F Months 212-66-2405 43 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD. WICOMICO SALISBURY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 DUCHESS DRIVE 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, 1 DYes 2 No ARMY If Yes, Give Year or Dales: Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify AFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER US POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) PORTER DEAL LOUISE LONG 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENEE T. DEAL 1525 DUCHESS DRIVE, SALISBURY, MD. 21801 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State SPRINGHILL MEMORY GARD. 2-10-00 HERBORN. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801 23a. Part. Enter the disease, or complications thei caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each frie. Approximete Interval Between Onsel and Death Immediate Ceuse (Final Respiratory Failure Due to (or as a consequence of): disease or condition resulting in death) ULTIORGAN SYSTEM FAILURE 10 d HYPEROSMALAN NON Ketotic Hyperglycemia Due to (or as e consequence of)

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760

ate has been signed page 2 should be de

tant: If Item 27 is

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

or itserns 23s or

Director

Funeral

Be

clan/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

30 d labetes Mellitus - New ONSet

Obes 1+4	entributing to death but not re-	sulting in the underlyin	g ceuse given in Part f.	1 Yes 2 No	3 Probably 4 Unknow
				24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?  1 □ Yes 2 No
25. Was case referred to medical			26. Place of D	eeth (Check only one)	
examiner? 1 Yes 2 No	Hospital: 154 Inpalient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)
27. Manner of Death 1 □ □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. fnjury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, fac	tory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
				ce, and due to the cause(s) and m curred at the time, dete end place	
29b. Signature and title of certifier			29c. License number	29d. Date signe	ed (Month, Day, Year)

02487

20+1VA

State Registrar

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fur

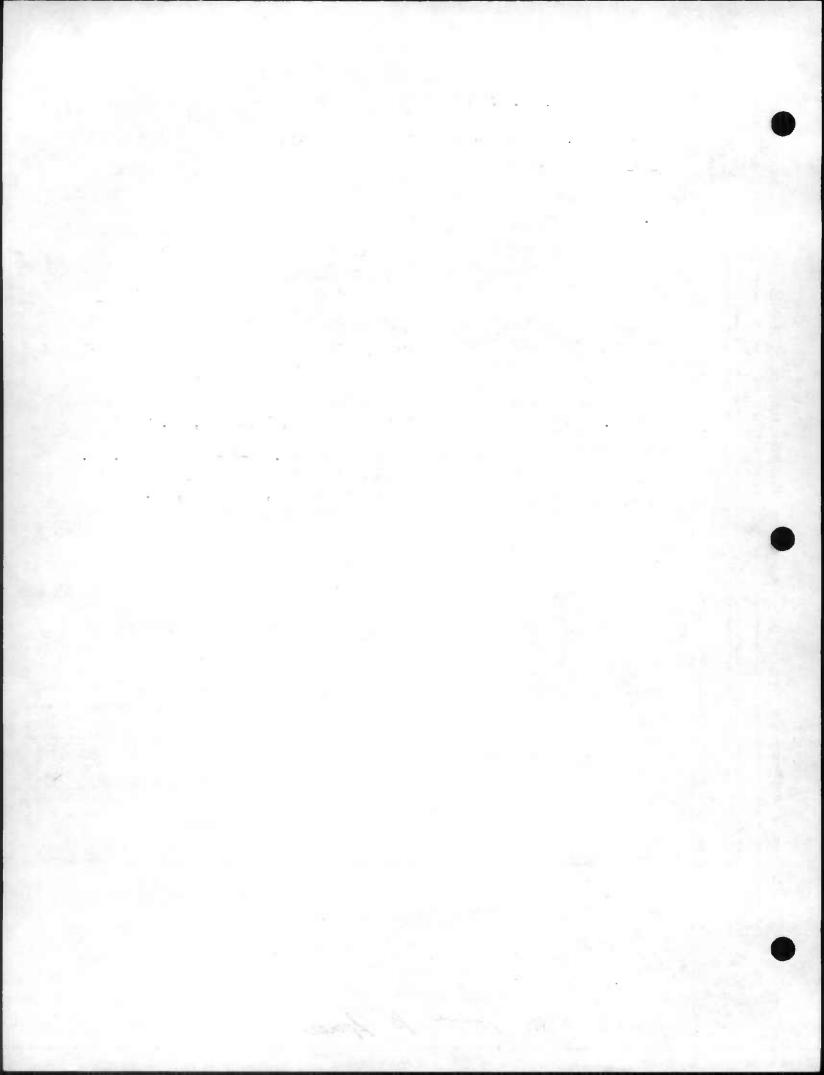
AUL FLEURY

Paul R Herry

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 560 RIVERSIDE DR SALISBURY Md.

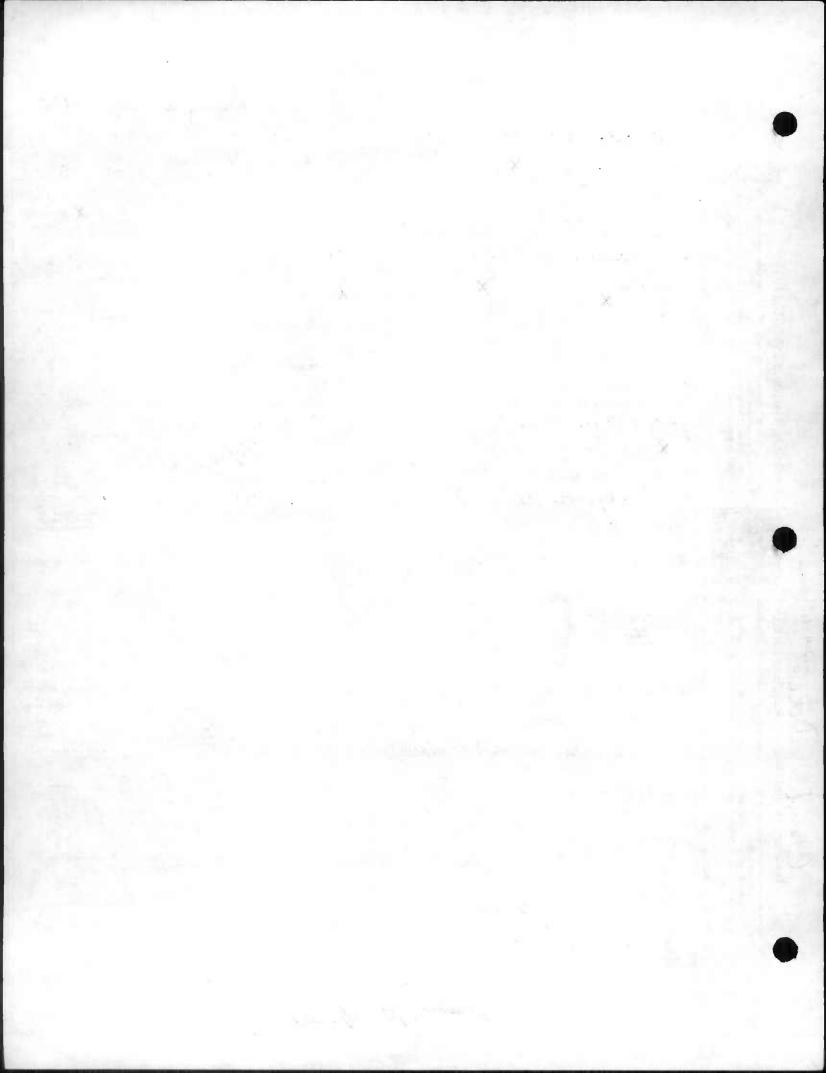
31. Date filed (Month, Day, Year)

32. Registrar's Signature



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

					rtificate of	Death		g. No.	JU	06216		
	Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	eath 3 Day Year		3. Time of Death					
	/Medical	Cheryl Margret	tta Doro	ce			tebruary	2	2000	1230		
	Examiner	4e Facility Neme (If not institution, give s				4b. City, Town, or Lo		4c. County	of Death			
		PENINSULA REGION	AL MEDICAI	L CENTER		SALISB	URY	WIC	OMICO			
	Funeral	5. Sociel Security Number 6. Sex	7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 9	Year)	9. Birthpi Coun	lace (State or Foreig		
	Director	214-68-6166	IM ZJAF	4.4 Yrs.			Dec.9	1955	Mary	aryland		
	p .	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town or L	nation				140	Del Jaciela Ciby I imite		
	ahou ahou								"	Od. Inside City Limits  1. Yes 2 □ No		
	the Marylar 28a-f ahon northed at	Maryland Wicomi	ico	Salisb								
	or 2	10e. Street and Number	10e. Street and Number 10f. Zip Code 10g. Citizen									
	th w	609 South Westor	ver Circl		21801		U.S.A					
	1 21215-0020 led within 72 hours efter death with the Maryland bygiene. Nor then "natural; or Nerms 23a or 28a-f show it, the Medical Emerican mant be notified as	11. Maritel Stetus	12. Wes Decedent Ev Armed Forces?	ver in U,S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, o			
0		1 Never Merried 2 Married	1 Yes 2 No		1 Yes 2 No			Specify				
21215-0020	db	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						Black			
ry.	natural.	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
121	within then the	Elementary/Secondery (0-12)	College (1-4or 5+)			9d)						
2	e filed with Hygiene other the vent, the vent, the vent, the sent,	10		Dom	estic	T		None				
Maryland	Mai H	17. Fether's Neme (First, Middle, Last)				18. Mother's Name		taiden Suman	10)			
=======================================	Men Men To	James Edward Hai				Ruth Co						
ā	2 sh and le m	19a. Informant's Neme/Relationship (Typ				t and Number or Run	HE - WALLES		- 11:			
4	and eelth m 27 her th	Margo Palmer (Si	ister)			elly Mill						
o o	of H	20e. Method of Disposition  1 Buriai 2 Cremetion 3 Re	emovel from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	nce)	Date 2	20c. Location -	City or To	wn, State		
E	Ped ant:	4 □ Donetion 5 □ Other (Specify)		Mt.Calv	ary Cem	netery	00 F	ruitla	and, M	Md.		
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other it eny Injury or other traumatic event, imponce.  To Be Cor	21 Signature of Funeral Service Licensee 22 Name and Address of Facility										
	89 = 8 9	Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801										
		23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused th							Approximate Interval Between		
	Physician	Shock, of heel gallure. List only on	e cause on each line.							Onset and Death		
	/Medical	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								1		
a	Examiner									days		
9	je je		is to for as a consequence ey.									
68760,	ificate be associted giphysician end as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):										
9 6	axe an er iniatt											
68760,	ysici ne bu											
89	E 0 0 =	resulting in Geetin) Less										
Box	andir use	d										
0	deat death de ath	Part II. Other significant conditions conf	tributing to death but	not resulting in the	inderlying cause o	iven in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death		
80	ires that tha death certification is gned by the attending discovers and by Physician/Mtd	0	0 4			1   Yes 2   No			3 Probably 4 Unknown			
3,4	bede e de	Congestin he	and failur	٠.								
/ital Records	clan: The law requires that the death cert artificate has been signed by the attending sofor, page 2 should be detached for use.  Be Completed by Physician/M	Congotin he					24a. Was ar	autopsy	24b. We	ere autopsy findings silable prior to		
္မ	w rew res s bee	Adriamy w	induced !	cardesmy	pathy		periorii	HOU?	COL	mpletion of cause death?		
a.	e ha age om				,		1 ☐ Ye	s 25 No	15	Yes 2 No		
Ta	ifficat or, p	25. Wes case referred to medicat				26. Place of Deat			1	2.00		
345	sich frect	evaminer?	ospitat:	2 ER/Outpatie	nt 3D DOA	thor	me 5 Reside	111	er (Granit	v)		
30	rthis aral o	27. Menper of Deeth	28a. Date of Injury (Month, Day )				28d. Describe ho			"		
2 5	Afte Afte	1 Natural 5 Pending 2 Accident investigation	ork? Yes 2 No									
- )	dee ctor: y the	3 Suicide 6 Could not be	28e. Plece of Injury	/ - At home, farm, st	reet, factory, office		28f. Location (St		ber or Rura	l Route Number,		
Divisi	after Dire	4 Homicide determined	City or Town									
	ours ours	29a, Certifier 10 Certifying Physi	ician: To the best of r	my knowledne deel	h occurred at the t	ime, date and place	and due to the co	use(s) and m	nner as et	ated.		
	To the Hospital or Attending Physician: The law requires that the death cert within 24 house deep deep deep deep deep deep deep de	(Check only 2   Medical Examin		xamination and/or in								
	Me Me	29b. Signeture and title of certiffer	- I I I I I I I I I I I I I I I I I I I		29c. Licen	ise number	25	d. Date signe	d (Month,	Day, Year)		
-	F ≱ F ŏ	D 81-114	mo		7	41721		- 1	2/00			
		Supria				( , / 5-1		10	-100			
		30. Neme end address of person who cor				0	0.4.	,				
		STEPHAN PAVLO 31. Date filed (Month, Day, Year)		00 E. SHORE	שע. >	ALISBURY M	10 21804	1				
	State	FER 0 4 2	32. Registrar's	acces -	4 1							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** В. DONAHUE JANUARY 30, 2000 0745 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OCEAN CITY WORCESTER 14501-C SINEPUXENT AVE. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2KDF Yrs. 63 Director 215-36-3794 SEPT. 7, 1936 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 Yes 2 No Directo WORCESTER MD OCEAN CITY 'natural', or flams 23s or 25s-f 10e. Street and Number 10f Zin Code 10a. Citizen of What Country? 14501-C SINEPUXENT 21842 USA AVE. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, Black. White, etc. Yes 2 No 1 Never Married 2 N Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiere. Elementary/Secondery (0-12) College (1-4or 5+) SALES REPRESENTATIVE NEWS PAPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be it and Mental F is marked off 2 WILLIAM C. BARNES ANNA ECKLOFF permit. Pages 1 and 2 sh. Department of Health and Important if Nem 27 is ma. any injury or 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN E. DONAHUE 14501-C SINEPUXENT AVE., OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) SALISBURY CREMATORY 1/31/00 SALISBURY, MD 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical YEARS Examiner Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 100 signed by t 1 Yes 2 No 3 Probably 4 Unknown UNKNOUN Records, P 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: director. Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nyes 2 No Certification: To this After thi funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Waturel death. 1 Yes 2 No 2 Accident after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a, Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06241 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 8 SNOW ST SNOW HILL MD. 21863

DHMH 16 Rav 6/95

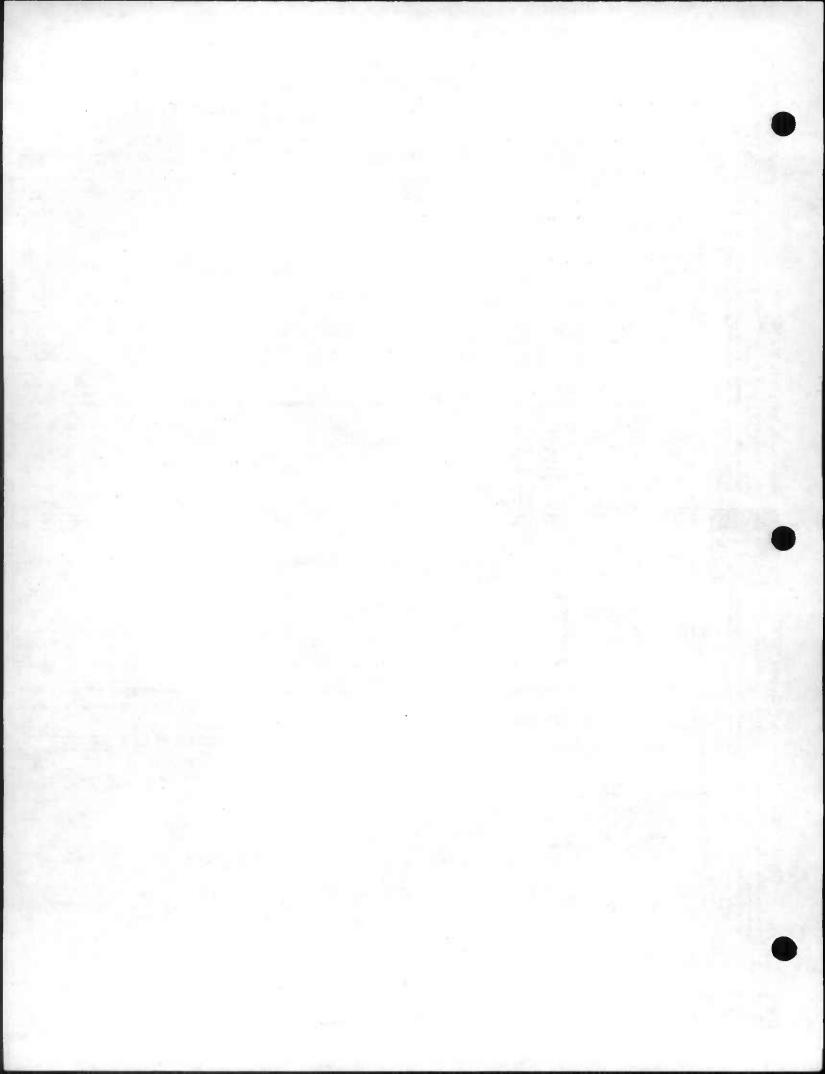
State Registrar ROTTHY

31. Date filed (Month, Cay, Year) 2000.

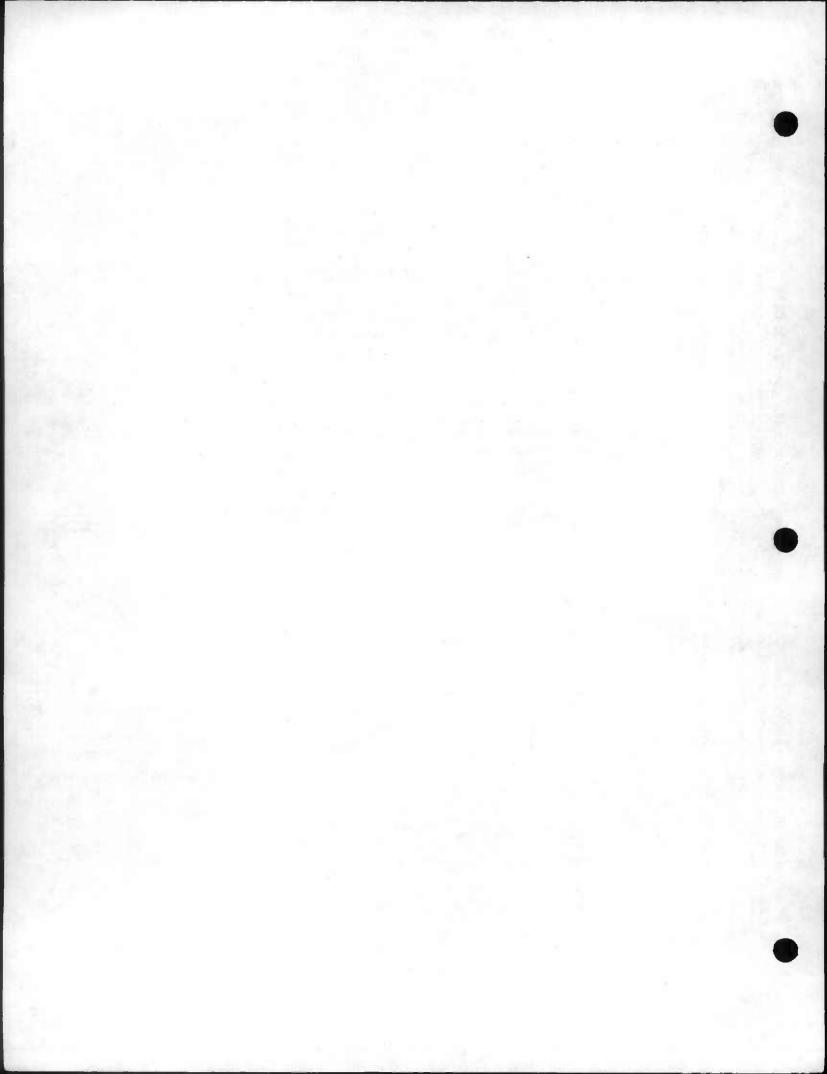
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IZWOZTH

32. Registrer's Signature



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		1⊠M 2□	16	s. last birthday) Yrs.	Months Days		. (Month, De		Birthplace (State or Country)
	-22-8740 esidence of Decedent		81				May 26,	1918	Maryland
10a. Sta		ly	10c. C	ity, Town or Lo	cation				10d. Inside City
100				7 . 1					1 🔯 Yes
MD 10a Sto	W1CC	mico		alisbur	10f. Zip Code			10g. Citizen of \	What Country?
		Dudana	4-4 201						
_	Canal Parl		Decedent Ever in		21804	ł Hispanic Origin? (	Coorie Van as Na	U.S.A	ce - American Indian,
	al Status Never Merried 28 Ma	Armo	ed Forces?	0,3.   13. ¥	Yes, specify Cub	an, Mexican, Pue	nto Rican, etc.)		ck, White, etc.
	Widowed 4 ☐ Divorce	. If Ye	e Give	III 1	☐ Yes 2⊠ No	Specify:		Specify	y: White
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Eleme	ntary/Secondary (0-12)		ge (1-4or 5+)		r & Open			Uorde	are Store
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	in S. Dash						e Freene		
	orment's Name/Relation			404 14-75-	- 4.14 (01	t and Number or R		-	
	aldine Dash	ilell (	Wife)	Place of Dispos		ark Drive	Apt.		isbury, MD : City or Town, State
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	Donation 5 Other		Ca		Cremato		1-31-00	Cambrio	dge, Maryla
21. Sign	eture of Funeral Service	e Licensee	11		Name and Addre				
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23a. Pa	rt1. Enter the disease, ock, or heart failure. Li	or complications t	that caused the dea						Approximate Intervel Betw
	on, or mount lande.	only one cause	or out mis.						Onset end D
Immedia	ite Cause (Finel or condition		16.11		1	Dize	4 - 0		1100
	in death)	a	Due to	(or as a consequence	uence of):				glag-
Sequen	ially list conditions	b. —	Due to	(or as a consequ	uence of):				
if eny, le cause.	ially list conditions, ading to immediate Enter Underlying								
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rant II. O	ther algnificant condi	ions contributing	to death but not re	Suring in the un	oenying cause gr	VORT WIT PORT I.		/	ontributs to the cause of
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							24a. Wes	en autopsy	24b. Were autopsy fir
							perto	rmed?	svailable prior to completion of ca
								/	of death?
							10	Yes 2 No	1 Yes 2 1
25. Was	case referred to medic						eth (Check only	one)	
10	res 20 No	Hospital:	1 npatient 2	ER/Outpatient	3LI DOM		Home 5 ☐ Resi	dence 6 Oth	ner (Specify)
	er of Death Vatural 5 ☐ Pend		Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe	now injury occur	rred
2□	Accident inves	figation			M 1	Yes 2□No			D. Care
	Suicide 6 ☐ Coule Homicide deter	mined 286. I	Place of Injury - At I	home, ferm, stre	et, fectory, office		28f. Location ( City or To		ber or Rural Route Numb
			and the second	,					
29a. Ce			the best of my kn						
on	ock only 2 Medica	Examiner: On t	he basis of examin manner steted.	ation end/or inv	estigation, in my o	opinion, deeth occ	urred et the time,	date end piece,	end due to the ceuse(s)
29b. Sig	nature and title of certif	er /	0		29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
	12	AM			0-	97,	19	1/2	1/11
30. Nam	and address of perso	who completed	cause of death (Ite	m 23a) /Time 5	Print)	-1.04	/	13	400
						CDITT	D 0300		
	IAM ROBINS, filed (Month, Day, Yea		1104 HEA 32. Registrar's Sign	11.00	DK. SALI	SBURY, M	n. 51804		
	FFRO	1 2000	A Company	B.	00000	Las			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Dey 20 Month 750 DORMAN 4b. City, Town, or Location of Death 2000 4a. Facility Neme (If not Institution, giva street and number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY
If Undar 1 Yaar If Under 24 Hrs. 8. Date
Months Days Hours Min. WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 6 8 Yrs. 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 12 M 20 F 215-26-4992 MAR Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1-Yes 2 No WICOMICO 10e. Street end Number 10g. Citizen of Whet Country? AUC eware 21801 12. Wes Decedant Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Reca - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 28 Married 1 ☐ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) FANKLIN J Elementery/Secondary (0-12) College (1-4or 5+) WORKER 16 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme, AMOS LUEMMA DORMAN 19a. Informent's Name/Reletionship (Type, Print) JAUGH LED) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ADRIAN DONIER DORMAN SALISBURY 1100 BRYDMANR DR. MD, 21804 20c. Location - City or Town, Steta 20a. Method of Disposition 20b. Pleca of Disposition Neme of cemetery, cremetory or other place) Date 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata St. JAMES FREE MY. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funerel Sarvice Licansee Bennie Smith Funeral Home, Salisbury made and art the mode of dying, such as cardiac or raspiretory errest, Approximately Petroen Intervel Between Onset end Death 23a. Pert 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest shock, or hear failure. List only one ceuse on each line. Immediate Ceuse (Finel diseese or condition resulting in death) Due to (or es e consequence of): OV discase Rectensive Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequenca of) Dua to (or es e consequance of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobecco use contribute to the cause of death? 3 Probably Unknown 1 Yee 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Tes 2 No

Amos Jornan Records. P.O. Box 68760, of Vital Division

The lew requires that the death certificate be axecuted and ettending physician I for use as the burie Physician/Medical detached been signed by the should be detached page 2 s certificate Attending Physician: director this funeral After death. Hospital or Attendii
 24 hours eftar death.
 Funeral Director: A letaly filled in by the following the To the Hospital within 24 hours e To the Funeral Completaly filled

by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

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nd Mental Hygiena. merked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is merked oth any Injury or other traumatic event once.

**Physician** 

/Medical Examiner

Maryland 21215-0020

Baltimore.

215-26-4992

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

0 State Registrar

Completed 25. Wes case referred to medical exeminer? Be 2 1 Yes Certification: 27. Menner of Deet 1 Neturel 2 Accident 5 Pending investigation 3 ☐ Sulcide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medicat Exeminer: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner stated. 29a. Certifier Medical 29b. Signature end title of certifier

29c. License number 829105

29d. Date signed (Month, Dey, Yeer) 2000

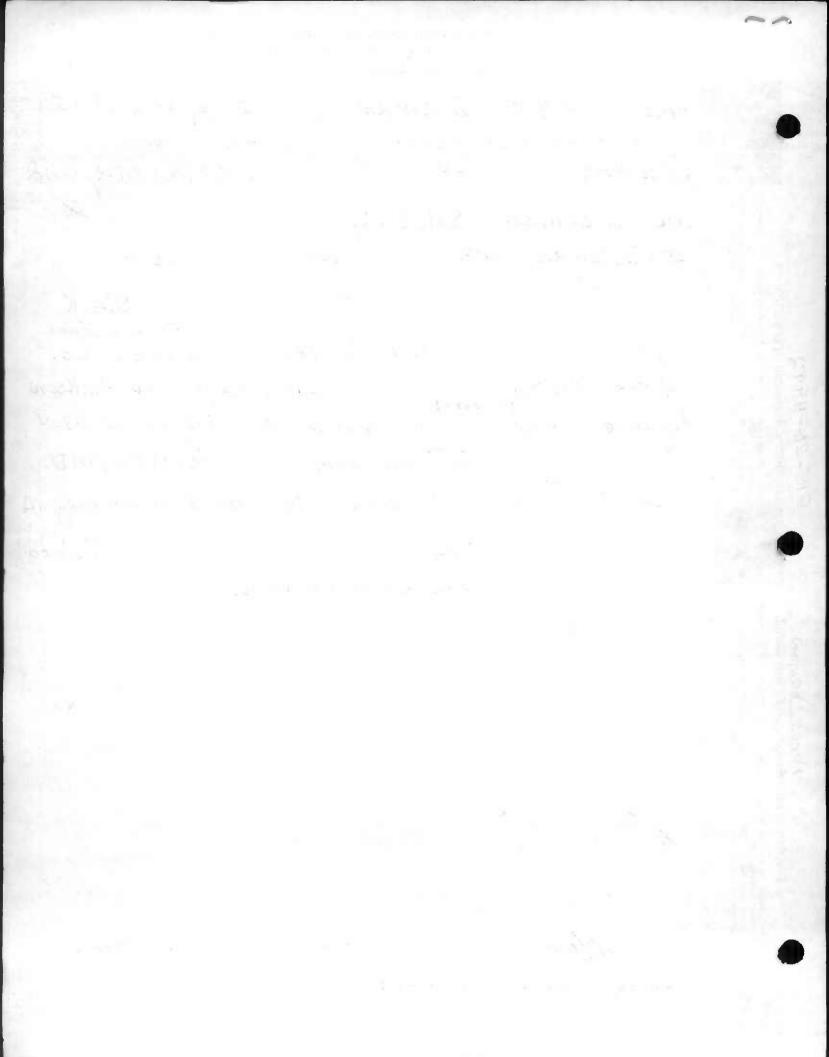
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Christian Huddleston 106 milford St.

31. Dete filad (Month, Day, Yeer) JAN 2 8 2000 32. Registrer's Signeture

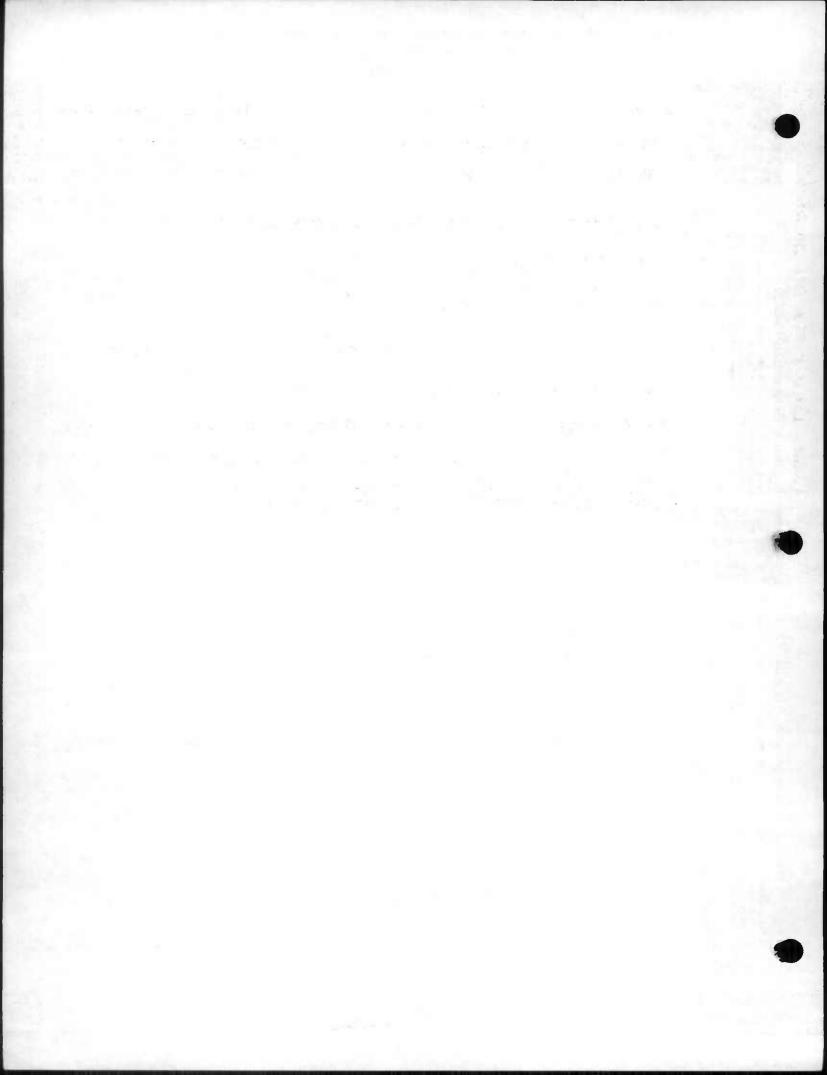
Salisbury md 21801



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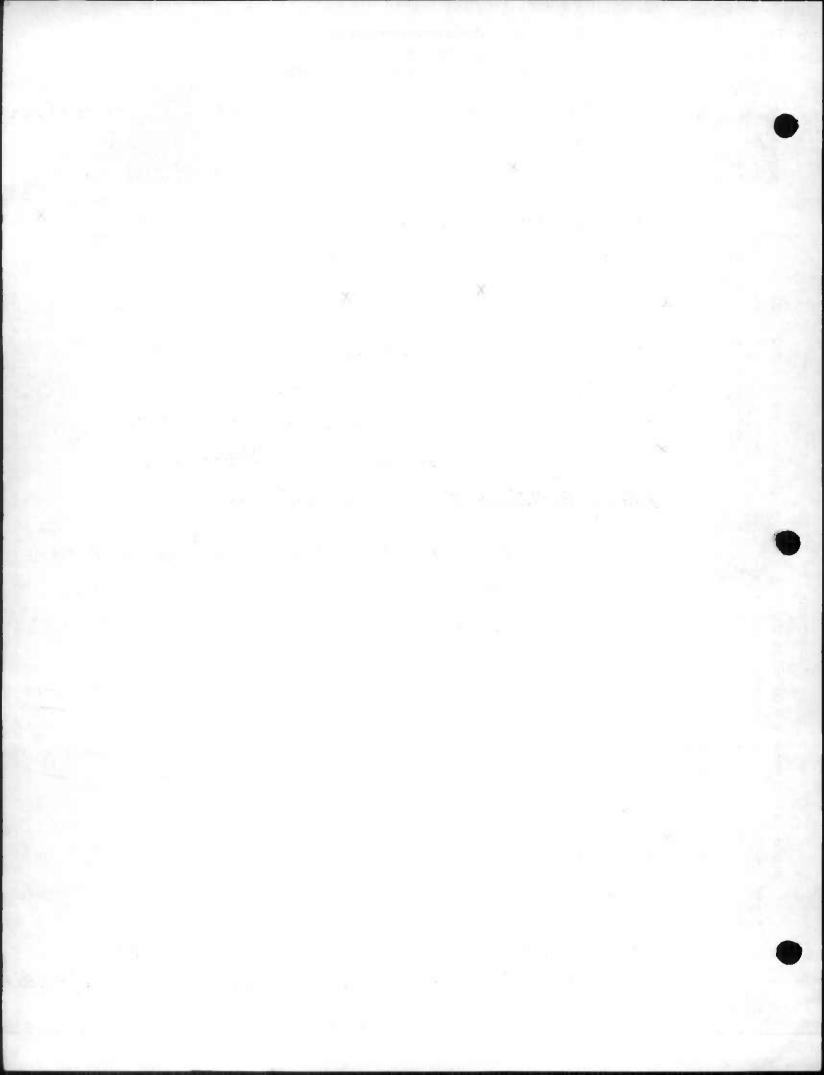
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dea	Funeral	11. Marital Stetus	12. Was Decedent E Armed Forces?	ver in U,S			enic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Rac	e - America		
72 hours efter death w netural', or items 23a	by	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Yeer or Detes:				Specify:	to Ricari, etc.)	Specify	k, White, e		
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should be end Mental s marked o	2	JAMES ASBURY	DAVIS,	SR			ANNA		MINNER			
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ges 1 and 2 should be filed within tof Health end Mental Hygiene. If item 27 is marked other than or other traumatic event, that Mental traumatic event, that Mental traumatic event, the Mental traum		RUTH E. DAVIS 20a. Method of Disposition		20b. Pl	P.O. BOX ece of Disposition (N	reme or	ANTIC /	VE. OCEA	N VIEW	DE J	9970	_
Pages nant of I nnt: If its iry or o		1 X Burial 2 ☐ Cremetion 3 ☐ Re	emovel from State	Ce	metery, cremetory of	r other plece)	77.5					
permit. Pages Department of Important: If if any injury or once.		4 Donetion 5 Other (Specify)  21. Signature of Foneral Service Diceptor	- 1	MAR	INER'S BE	THEL CI		1/23/00	OCEAN V	TEW,	DELAWAR	E
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State of Maryland / Department of Health and Mental Hygiene

			1 Decodont's Name (First Middle Leet)	Certificate of	Death		g. No.	00221
Г	Physic		1. Decedent's Nama (First, Middle, Last)  Renager Genieve Dutton			2. Data of Death Month January	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, giva straat and number)		4b. City, Town, or Lo		4c. County of Dea	1100/11
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	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Aga (In yrs. last b	virthday) If Under 1 Year Months Days	If Un r 2 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 5	9. 8ir 1915 Ma	thplace (Stata or Foreign ountry) aryland
	puel Mo			wn or Location				10d. Inside City Limits
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	or 28	lrec	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a	la	717 Richmond Avenue	2180	1	Ţ	J.S.A	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mentiel Hygiane. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be received an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad  12. Was Decedant Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yaar or Dates:	13. Was Decedant of H If Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, atc.)	14. Race - Ame Black, White Specify: B1	
Ö	2 hou	ted	15. Decedent's Education 16s	a. Decedent's Usual Occup	pation	, 1	6b. Kind of Business	
2	ithin 7	Completed	(Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+)  1 2	(Give kind of work dona life. DO NOT usa retire	during most of work d)	Ing		
2	Hygian Hygian ther th	Con		Domestic			None	
anc	if be fi	Be	17. Father's Nama (First, Middle, Last)		18. Mother's Name		aiden Sumame)	
Ž	should be nd Mentel marked o	70	John Barkley  19a. Informant's Name/Relationship (Type, Print)  19	the Administration of Change	Annie A		O: - T - O: -	7.0.1
Ma	and 2 s saith en 3 27 is r er trau			b. Meiling Address (Street				
re,	Health tem 27 other tr		20a. Method of Disposition 20b. Placa	24 N. Curle of Disposition (Name of ery, crematory or other pla		1	Oc. Location - City or	
OE .	Pages net of i		1200 Unai 2 Li Ciamation 3 Li Removal non State		ce)		alisbury	
<b>=</b>	permit. Pag Department Important: I any Injury o		21. Signature of Funarai Servica Licansae	n Acres	ass of Facility		alisbury	, Ma.
m	Depa Impo any Ir		Iladys B. Stewart	Stewart	Funeral		12 01001	
	_		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	821 West				Approximate
	Physician		23a. Part1. Enter the dispase, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a b					Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition A B D D M	INAL 1	AUBTIC	ANI	EULYSM	8 DAVI)
	LAGIIIIIGI	76	resulting in death)  Due to (or as a	consequence of):				
	ted nsit	nlin	b. HYPERT	ENSION	/			YKJ
-6	el-tra	Examiner	Sequentially list conditions, Due to (or as a if any, leeding to immediate	consequenca of):				
68760,	tificate be executed ng physician end es the buriel-transit							YRJ
	ifficat g phy es th	Medicai	resulting in death) Last	consequence of):				
ROX	death certificate be executed e ettending physician end od for use es the buriel-transit	N/Jue	d					
Б	deat	Physician/	Part II. Other significant conditions contributing to death but not resulting	In the underlying cause gli-	ven in Part I.	23b. Did tob	acco use contribute	to the cause of death?
٦.	res that the designed by the ellbe detached f	Phy				1 □ Ye	2 □ No 3 □ P	robably 4 Unknown
S,	signed d be d	by						
Hecords,	requiper shoul	Completed				24a. Wes en perform	ed?	Were eutopsy findings available prior to completion of cause of deeth?
	The law ste has page 2	E O				1 🗆 Yes	2 10 No	1 ☐ Yas 2 ☐ No
Ita	ysician: Tha I s certificate ha director, page	Be (	25. Was case referred to medical examiner?		26. Place of Deatl	(Check only one	)	
2	Physician: r this certific and director,	10	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	dipatient 3L DOA	ner: 4 ☐ Nursing Ho		ca 6 □Other (Spe	ocity)
Š	Ing P	on:	1 Natural 5 Pending (Month, Day Year)	Time of tnjury 28c. Injur		28d. Dascribe hov	v injury occurred	
Division of Vital	r Attending Per death.	Certification:	2 Accident investigation 3 Sulcide 6 Could not be		Yes 2 □ No	201 1 201		18
$\leq$	25-	artif	determined  4 Homicide  determined  28a. Placa of Injury - At home, for building, etc. (Specify)	arm, street, factory, office		City or Town,	eet and Number or R State)	urai Houte Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical Co	29a. Certifier (Check only one)  29 Medicat Examiner: On the basis of examination as and manner stated	e, death occurred at the tir nd/or investigetion, in my c	me, date and place,	end due to the cau	use(s) and manner e	s steted. e to the cause(s)
	ithin ithe or the or the or the	Mec	one) and manner stated.  29b. Signature and title of cartifier	29c. Licens	se number	29	d. Date signed (Mont	th Day Year)
	F ≥ F 8		101111	00	1910	23	1-04	A A
			30. Name and eddress of person who completed cause of deeth (Item 23a)	(Tune Print)	117		1-27-	UU
	6		Tr John's Chaning Continued cande of deem (New 238)	> Fretonin	Show	Noire	Solich	sisam, masis
	Sta	tę	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 451411	UNGE	ONC	Cuisn	U), wan
	Registr	_	WAN 2 1 2000 Sancera	6 1				



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middle,	Last)		Certifi	cate of	Dealli	2. Data of D	Reg. No.	U	3. Tima of Death
cian	NORA V.						Month JANUAR	Day	Year 000	4:54 AM
	48 Facility Nama (If not institution,	DAY giva street and number	r)	_		4b. City, Town, or				4:34 AM
	MEMORIAL HOSPITA	AT & MEDICA	T CEN	TED		CUMBERL	ANID			
		6. Sex 7. A		last birthday) H	Under 1 Yaar onths Days	If Under 24 Hr	s. 8. Data of B	ALLE		place (Stata or Foreig
-	234-68-4821 Usual Residence of Decedent	1□ M 2\\ F	85	Yrs.	Julius Days	Tiours Mil	Jan. 2	22,1915		Virginia
1	10a. Stata 10b. County		10c. City	, Town or Location	n				1	0d. Inside City Limit
L		Legany		Rawli						
	10e. Street and Number			1	0f. Zip Code			10g. Citizen of	What Cour	ntry?
ŀ	Rt. 3, Box 9	5-A 12. Was Deceden	4 Ever in 114	C 12 Wee	215		Conside Van er N	US.	A ce - Americ	en Indian
	11. Marital Status  1 Never Married 2 Marrie  3 X Widowed 4 Divorced	Armed Forces	? ] No		s, specify Cut	Hispanic Origin? ( san, Mexican, Pua Specify:	nto Rican, atc.)	Bla Specif	ck, White,	
-	15. Decedent's			16a. Decedent'	Usual Occu	nation		16b. Kind of B	-	
	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Giva kind	of work done IOT use retire	during most of w	orking			
ŀ	17. Father's Nama (First, Middle, L	est)		COOK		18. Mothar's Na	ma (First, Middle	e, Maiden Sumar	taura	nt
	William Eldri		1				R. Sowe			
	19a. Informant's Name/Relationsh	0	_	19b. Mailing A	drass (Stree	t and Number or F			State, Zic	Code)
	Harold I. Day/S			The state of the s				The second		, MD 2155
	20a. Method of Disposition		20b. Pl	lace of Dispositio	(Nama of		Data	20c. Location		
	1 Burial 2 Cremation 3 4 Donation 5 Other (Sp.			ematary, cremato			Feb. 1	Dedeate	T 777	
ŀ	21. Signature of Funeral Service L		Wes	sley Cha		metery ass of Facility	2000	Points	, WV	
	D R	11 01	1	S	mith F	uneral H				
	23a. Part1. Enter the disease, or	Duite	ed the death			ain Stre		eyser, W	V 26	726 Approximata
completed by ringsicialymedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or	as a consequence	B be	osiella p eta hemol				
		d			100					
	Part II. Other significant condition	s contributing to death	but not resu	ilting In the under	ying causa gi	ven in Part I.	23b. Dic	d tobacco use co	entribute t	o the cause of deati
	Chronic obstruc cerebrovascular	accident w	ary d	isease, onsequer	right t left		10	Yes 2 No	3 Pro	bebly # Unknow
]	hemiparesis and	contractur	es, d	ementia	-		24a. Wa	s an autopsy formed?	av	ere autopsy findings allable prior to impletion of cause death?
	multi-infarct							Yes 25 No		Yes 2 No
	25. Was case refarred to medical					OC Diseased D	eath (Check only			1163 20140
	axaminer? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 I	ER/Outpatient 3	CI DOA OI	han		sidence 6 Ott	nar (Canai	hal.
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigs	28a. Data of Inj (Month, D	ury	28b. Tima of Injury	28c. Inju			how injury occur		<i>yı</i>
	3 Suicide 6 Could no detarmin	A Zoe. Place of in	njury - At ho	ma, farm, street,	actory, office		28f. Location City or To	(Street and Numi	ber or Rura	al Routa Number,
	(Check only 2   Medical E	Physician: To the best	of axaminati	vledge, death occion and/or investi	urred at tha t	ma, data and place	e, and due to the	a cause(s) and m	anner as s	taled, o the cause(s)
	one) 296. Signature and title of certifier	and manner s	nated.		29c. Licen	se number		29d. Date signe	ed (Month,	Day, Year)
	My m	1 1/	-	7.	DO	054411		1	28	2000
	30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, Print		OJTTI		1	700	2000
e	BEVERLY CALKINS 31. Data filed (Month, Day, Year) FEB 0 8 20	32. Regist	trar's Signat		MED BL	DG, 500	MEMORIA	L AVE.,	CUMBE	ERLAND, ME

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

TO COOLEY CARRY Member of Control Cont					e of Death	R	eg. No.	10663
TO STATE OF THE BAND AND AND AND AND AND AND AND AND AND	Physician							
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Social Scientific Control	Examiner				4b. City, Town, or	Location of Death	4c. County of Deatl	h
215-19-31-82  21		764 CLEVELAND	AVE					1 Y
Compared   The County   The C	Funeral				1 Year If Under 24 Hr	8. Dete of Birth	Year) 9. Birti	hplace (State or Foreign
Use a Place According to the Country   Voc. City, Term or Location   Library   Voc.	Director	215-18-8182	95	Yrs.		APR 5	1904 MAF	
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The second process of the part of months of the part o	re ire	10e. Street and Number		10f. Zig	Code	1	0g. Citizen of What Co	untry?
Topic   Control   Contro	13a c	764 CLEVELAND	AVE.	2	1502		IISA	
Topic   Control   Contro	deat deat	11. Marital Status	12. Was Decedent Ever in L			Specify Yes or No-	14. Reca - Amer	
Comparison of physical grade completed   College (1-40 to 1)   C	Fur Fur	1 Never Married 2 Merried	1 TYes 2 TXNo			rto Rican, etc.)		
Comparison of the property o	DZ Urs s	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1 ☐ Yes	21 No Specify:		Specify: WHI	TE
SUPERVISOR  MARTHA LEE UNKNOWN  The Informatic Name-Relationship (Fige. Rhing)  DALE DARROW/SON  JOHN Marth Disposition  JOHN MART	De po	15. Decedent's Ed	ucation	16a. Decedent's Usu	al Occupation		16b. Kind of Business/l	ndustry
The principle of the pr	Par	(Specify only highest grad	fe completed)	(Give kind of wo	ork done during most of wa se retired)	orking	AND DESIGNATION OF THE PARTY OF	
The principle of the pr	with some	Elementary/Secondary (0-12)	College (1-4or 5+)	SUPERVI	SOR		FDUCATI	ON
DALE DAM MAC MILLIAN  19a. Informart's Name/Potelloineting (Type, Print)  19b. Making Address (Sizent and Number or Pural Reces Number, Circle  20b. Making Address (Sizent and Number or Pural Reces Number, Circle  20c. Makend of Disposation  10 Septial 22 D'Commenton 3   Removal from Stets  10 Septial 22 D'Commenton 5   D'Commento	D HE TO O	17. Father's Neme (First, Middle, Last)				ma (First, Middle,		.011
20. Person of Disposition (Name of Disposition (Nam	d be od o B o	ADAM MAC MILLIA	A N		МЛРТИ	A LEE II	NKNOWN	
20. Person of Disposition (Name of Disposition (Nam	T MAN THE T			10h Mailine Addens				En Code)
20. Person of Disposition (Planes 2000) 20. Responded of Disposition	Ma 12 s 14 s 1 s 1 s 1 s			I die c				
Physician Medical Examiner  The description of the second	CEN L							
Physician Medical Examiner  The control of the cause of t	0 85 86	The second secon	Removel from Stete	cemetery, crematory or o			20c. Location - City of	I own, Stete
Physician Medical Examiner  The control of the cause of t	E de th		FR	OSTBURG MI	EMORIAL PA	RR	FROSTBURG	. MD
Physician Medical Examiner  The control of the cause of t	to Haday	1. Signature of Funeral Service Licens	500					
Physician Physic	m 28118	1 0 8	1/1/					
Physician (Medical Examiner)    Part II Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I.		23a. Part1. Enter the course, or comp	lications thet caused the dea	th. Do not entar tha mor	de of dving, such es cardie	C or raspiretory arr	ALF, MU 21	5 0 2 Approximete
The clical Examiner	Physician	shock, or heart tail. List only of	ne cause on aech lina.					Interval Batween Onset end Death
Security		Immediata Causa (Finat	6.1010	AL-	1 . 1	0 -		2
Due to (or as a consequence of):    Due to (or as a consequence of):		disease or condition	· Chasta	ge 1/12	nemers	D150.	re i	JURS
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Course (Disease or injury to the course of injury to t	and I-tran	Sequentially list conditions,	Due to (	or as e consequenca of):				
Described to the cause of death but not rasulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death?   1   Yes 2   Yes   1   Yes   Yes   1   Yes 2   Yes   1   Yes	Se surial	causa. Enter Underlying	•					
Described to the cause of death but not rasulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death?   1   Yes 2   Yes   1   Yes   Yes   1   Yes 2   Yes   1   Yes	876 hysic the basic the ba	that initieted events resulting in death) Last	Due to (c	or as a consequence of):			1	
24a. Was an eutopsy performed?  24b. Were eutopsy lindings evenliable prior to completion of cause of death?  1   Yes   2   No    25. Was case referred to medical evaminer?  1   Yes   2   No    25. Was case referred to medical evaminer?  1   Yes   2   No    26. Place of Deeth (Check only orgat) evanishing of death)  27. Mennger Death  1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   28c. In	0 = 22 0							
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25. Was case referred to medical swaminer?	Has has							ot death?
27. Menner of Death 1 Netural 2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   7   State   7   Menner of Death 1   Netural   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Pending investigation   6   Could not be determined   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   7   Menner of Death   1   Netural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Be. Pleca of Injury At home, larm, street, factory, office   2   Set Injury at Work?   1   Yes 2   No   2   Set Injury at W	= F # 8 0					1  Y	es 2DNo 1	I ☐ Yes 2 ☐ No
27. Menner of Death 1 Netural 2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   7   State   7   Menner of Death 1   Netural   2   Accident   3   Suicide   4   Homicide   7   Pending investigation   6   Could not be determined   7   Pending investigation   8   Pleca of Injury   At home, larm, street, factory, office   7   Pending investigation   8   Pleca of Injury   At home, larm, street, factory, office   7   Pending investigation   8   Pleca of Injury   At home, larm, street, factory, office   7   Pending investigation   8   Pleca of Injury   At home, larm, street, factory, office   7   Pending investigation   8   Pleca of Injury   At home, larm, street, factory, office   8   Pleca of Injury   8   Pleca of Injury   9   Pleca of Injury   At home, larm, street, factory, office   9   Pleca of Injury   9	/itt	examiner?				eth (Check only or		
16   Netural   2   Accident   3   Suicide   4   Homicide   4   Homicide   29a. Certifier (Check only one)   29b. Signature and title   Check only one)   29b. Signature and title   Check only one)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   29c. License number   29d. Dete signed (Month, Day, Year)   FEB 4, 2000   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   20c. License number   29d. Dete signed (Month, Day, Year)   29d. Detection (Street and Number or Rural Route Number, of the cause (s) and manner estated.   29c. License number   29d. Dete signed (Month, Day, Year)   29d. Detection (Street and Number or Rural Route Number, of the cause (s) and manner estated.   29c. License number   29d. Detection (Month, Day, Year)   29d. Detection (Month)	To To	1 ☐ Yes 2 ☐ No	1 Inpatient 2L		DA 4 Nursing	Home 5 Rasid	ence 6 Other (Spec	cify)
30. Name and address of person who compresed cause of death (Item 23a) (Type, Print)  DR. G. WAGONER 925 Seton Dr. Cumberland MD 21502  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of perso	D C D D D D D D D D D D D D D D D D D D		28a. Date of Injury (Month. Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe h	ow injury occurred	
30. Name and address of person who compresed cause of death (Item 23a) (Type, Print)  DR. G. WAGONER 925 Seton Dr. Cumberland MD 21502  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of perso	ion ather at of the set of the se	1 A1 A	(11,111,111,111,111,111,111,111,111,111					
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30. Name and address of person who compresed cause of death (Item 23a) (Type, Print)  DR. G. WAGONER 925 Seton Dr. Cumberland MD 21502  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  State  31. Discussion of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of person who compressed cause of death (Item 23a) (Type, Print)  A second of person of perso	dica dica	(Check only 2 Medical Exam	ner: On the besis of examine	etion and/or investigation	, in my opinion, daath occ	urred at tha time, d	ate and placa, end due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 00

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	1. Decedent's Name (	First, Middle, La	ist)						2. Dete d		Day	Yeer	3. Time of Death
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Examiner	4e Facility Neme (If no							4b. City, Town,		Death	4c. County		
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Funeral Director	5. Sociei Security Num 213–18–2	216	Sex 1□M 2√F	7. Age (In yrs. 93	Vrs.	If Under 1	Days		in. (Mont/	f Birth n, Dey, Ye 21, 1	1906 V	9. Birthp Cour VEST	place (State or Foreign ntry) VIRGINIA
£ 11	Usual Residence of Do	Ob. County		10c. Cit	y, Town or Lo	cation						. 1	10d. Inside City Limits
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ysician Medicai aminer	Immediate Cause (Fir disease or condition resulting In death)			brovas									Onset and Death  2 weeks
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igned by the ettendir be detached for use by Physician/N	Coronar				anny in the ui	Johnymig Ca	naa Au	roll in Foll I.	230.	1 Yes	2X No		obably 4 Unknow
should should	Hyperte	nsion							240.	Was en a performed	utopsy 1?	81	Vere autopsy findings vailable prior to ompletion of cause f death?
page 2										1 ☐ Yes	2 No		□Yes 2□No
rector, pag	25. Was case referred	to medical						26. Place of	Deeth (Check o		27		
200	examiner? 1 Yes 2 No		1		ER/Outpatien			ner: 4 Nursin	g Home 5 🗆		e 6 DOth	ner (Speci	ify)
After ti funera fion:	2 Accident	5 Pending Investigation	n	of Injury h, Dey Year)	28b. Time of Injury	M 28	ic. Injui Wo 1 □	ry et rk?  Yes 2 □ No	28d. Desc	ribe how i	injury occur	red	
within 24 hours effer death.  To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 Could not be determined	200. FIEU	of Injury - At h	ome, farm, str	eet, factory.	office			ion (Stree r Town, S		ber or Run	ral Route Number,
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 15 (Check only 20 one) 2	Certifying Pi	nyalclan: To the minar: On the ba end mann	sis of examine	wledge, deeth	occurred e restigetion,	t the ti	me, date and plo ppinion, deeth o	ace, end due to courred et the t	the ceus ime, dete	e(s) end m and plece,	anner as s end due t	stated. to the cause(s)
E P	29b. Signature and Jilly	e of certifier				29c.	Licens	se number		29d.	Date signe	d (Month,	Dey, Year)
200		A					332				bruar		

Sunil K. Gupta, M.D. -625 Kent Avenue, Curberland, MD

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State Registrar

William Sherry York

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State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility Name (If no	ot institution, gi	ve street and n	umber)			4	b. City, Tow	m, or Loca	tion of Deat	4c. Cour	ity of Death	1
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Funeral	5. Social Security Num		Sex	7. Age	(In yrs. last birthe	Months	1 Yeer Deys	If Under 2	Min.	. Date of Bir (Month, De	th v. Year)	9. Birth	place (State or Fore
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her death. Irector: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use at riffication: To Be Completed by Physician/Me	cause. Enter Underfyll Ceuse (Disease or injuthat initiated events resulting in death) Last  Pert II. Other significate  25. Was cese referred examiner?  1 Yes 2 No  27. Manner of Death 1 Netural 5 2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only one)	to medical	Hospitel: 1 28a. Dete (More 1) 28a. Plec builk	Dudeath but  Inpatient a of Injury nth, Day 1 can of Injury ding, etc.	not resulting in the second se	atient 3 DO  ne of 2  no, street, factory	8c. Injuny World	26. Place of the property of t	lo 28	24a. Wesperfo	en autopsy mmed?  Yes 2 No one)  dence 6 C how injury occurse(s) and dence of leading and place of the part place.	24b. V 24b. V 24b. V 30 11  Other (Special results of the second r	Vere autopsy finding variable prior to completion of cause of death?  Yes 2 No  if yes 2 No  ral Route Number,  stated. to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	cause. Enter Underfyll Ceuse (Disease or injuthat initiated events resulting in death) Last  Pert II. Other significate  25. Was cese referred examiner?  1 Yes  27. Manner of Death  1 Netural  2 Accident  3 Suicide  4 Homicide	to medical	Hospitel: 1 28a. Dete (More 1) 28a. Plec builk	Dudeath but  Inpatient a of Injury nth, Day 1 ce of fnjurg ting, etc.	not resulting in the second se	atient 3 DO  ne of 2  no, street, factory	8c. Injuny World	26. Place of the property of t	lo 28	24a. Wesperfo	en autopsy mmed?  Yes 2 No one)  dence 6 C how injury occurse(s) and dence of leading and place of the part place.	24b. V 24b. V a c c c c d ther (Spec	Vere autopsy finding vailable prior to completion of cause if death?  Yes 2 No  if yes 2 No  ral Route Number,  stated. to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as AMedical Certification: To Be Completed by Physician/Me	cause. Enter Underfyll Ceuse (Disease or injuthat initiated events resulting in death) Last  Pert II. Other significate  25. Was cese referred examiner?  1 Yes 2 No  27. Manner of Death 1 Netural 5 2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only one)	to medical	Hospitel: 1 28a. Dete (More 1) 28a. Plec builk	Dudeath but  Inpatient a of Injury nth, Day 1 ce of fnjurg ting, etc.	not resulting in the second se	atient 3 DO  ne of 2  no, street, factory	8c. Injuny World	26. Place of the property of t	lo 28	24a. Wesperfo	en autopsy mmed?  Yes 2 No one)  dence 6 C how injury occurse(s) and dence of leading and place of the part place.	24b. V 24b. V a c c c c d ther (Spec	Vere autopsy finding variable prior to completion of cause of death?  Yes 2 No  Prify)  Tal Route Number,  stated. to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	cause. Enter Underfyll Ceuse (Disease or injuthat initiated events resulting in death) Last  Pert II. Other significate  25. Was cese referred examiner?  1 Yes 2 No  27. Manner of Death 1 Netural 5 2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only one)	to medical	Hospitel: 1 28a. Dete (Mon Mon Mon Mon Mon Mon Mon Mon Mon Mon	death but  I Inpatient of Injury oth, Day 1  the best of the basis of element stete	not resulting in the second resulting re	atient 3 DO  ne of 2  no, street, factory	8c. Injuny World	26. Place of the property of t	lo 28	24a. Wes performed to the control of	en autopsy mmed?  Yes 2 No one)  dence 6 C how injury occurse(s) and dence of leading and place of the part place.	24b. V 24	Vere autopsy finding variable prior to completion of cause of death?  Yes 2 No  No.

Leo Frederick Dean

Sacred Heart Hospital

219-113-8192

CI

Leo Hedenck Dean

Amy Snyder

Alleriany in Apr-20 Maryland

Cumberland

Maryland Allegany Frostburg

90 Braddock Road

21532-

White

owner/operator

41 1 11-11 1

Mary Martha Hammelwright

preathnese litis Braddock Road Frostburg Maryland 21552-

For abusing Memoral East 10-Feb-00 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

### Piease Type or Print in Biack Indelibie ink. Assure Aii Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month Year Harry E. Devore

Months

Maintenance

20b. Place of Disposition (Name of cemetery, cremetory or other place)

HepatoreNot Syndrome

advocaranona of the colory

Due to (or as a consequence of):

Dua to (or as a consequence of):

LMER Falure

Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA

28b. Time of

28a. Dete of Injury (Month, Day Year)

10f. Zip Code

21502

1 ☐ Yes 2 ☑ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

Lavale

74

**Physician** /Medical Examiner

**Funeral** Director

r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 72 hours after permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Mental Hyglene. Important: if Itam 27 is marked other than "na any Injury or other traumatic avant, in Made page.

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner Examiner attending physician end for use as the burial-transit Box 68760 Physician/Medical P.O. signed by t Records, þ I or Attending Physician: The law requires t after deeth. Director: After this certificete has been sign Completed Division of Vital director. Be Certification: To To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b edicai WI

Sacred Heart Hospital 5. Social Security Number 210-12-9117 1 M 2 F Usual Rasidance of Decedent 10a. Stata 10b. County Maryland Director Allegany 10e. Street and Number 9 Asbury Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 N Yes 2 No W W TF If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Nema (First, Middla, Last) Be John E. DeVore 19a. Informant's Name/Reletionship (Type, Print) Dorothy Devore/Wife 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funaral Sarvice Licensee 23a. Part 1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or haart failura. List only one ceuse on aech lina. Immediata Cause (Finel disaesa or condition rasulting in death) Sequantially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last colorcital metastases to Liver Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceusa given in Part I.

4a Facility Nama (If not institution, giva street and number)

25. Wes case referred to medical axaminer?

1 Yas 2 No 27. Menner of Death 1 Natural 2 Accidant 29a. Certifiar

invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier Amelalle. Storto MD

5 Pending

29c. License number D5315D

1 Yes 2 No

29d. Data signed (Month, Day, Year)

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print).

MICHAEL W., STASKO 934 SCHON Drive Cumberland MD 32. Registrar's Signatura

28c. Injury at Work?

State Registrar

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year)

JAN 3 1 2000

& sports

**ORIGINAL** 

28f. Location (Street and Number or Rural Routs Number, City or Town, Stete)

JANUARY 27, 2000

8. Date of Birth June 23, 1925

18. Mother's Name (First, Middle, Meiden Surname)

Data

4c. County of Death

Allegany

10g. Citizen of What Country?

United States

14. Race - American Indian, Black, Whita, atc.

Specity: White

16b. Kind of Business/Industry

Postal Service

20c. Location - City or Town, Stata

4b. City. Town, or Location of Death

Cumberland
If Under 1 Year | If Under 24 Hrs. | 8. Date

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.)

Sarah Tyson

9 Asbury Avenue LaVale, Maryland 21502

Palo Alto Hilltop January 29, 2000 Hyndman, PA 22. Name and Address of Facility Harvey H. Zeigler Funeral Home

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

Days

6:50 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximata Intervel Between Onset and Death

3 clay 5

3400-5

24b. Wera autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ¥ Yas 2 No

Maryland

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 28 No

28d. Describe how injury occurred

1 Yes 2 10 3 Probably 4 Unknown

JANUARY 27, 2000

JANET 2000 Brown to Species

		Decedant's Nama (First, Middle	Last)		Cei	unca	ie oi	Death	10.	Re Data of Death	g. No.		2 Time of Dear
ysician	_									Month	Day	Yaar	3. Tima of Deeth
ledical	_	Daisy Belle le. Fecility Nama (If not institution)		herl				4b. City, Towr		bruary	4c. Count	)00  -	5:20 AM
aminer	1	Colton Villa	•					Hagers		ar or Dectri		ington	
eral		i. Social Security Number	6. Sax 7		. last birthday)		ar 1 Year	r If Undar 24		Data of Birth Month, Dey,		-	a (State or Foreig
tor		235-70-2477  Usuai Rasidence of Dacedant	1□M 2∏F	104	Yrs.	Months	Deys	Hours	Min. Ju	ne 15,	1895	Virgi	nia
by Funeral Director		10a. Stata 10b. County		10c. C	ity, Town or Lo	cation						10d	. Insida City Limits
cto		W. Va. Jeffe	rson	Ha	rpers F	erry							1XX as 2 No
Dire		Oe. Street end Number				10f. Zi	ip Coda			10	g. Citizan of	What Country	?
- E	5	600 Washington				-	5425					JSA	
by Funeral Director	23	Marital Status     Never Marriad 2 Marria     Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yas 2 It Yas, Giva Year or Dat	as? No		Wes Dace f Yas, spe 1 ☐ Yas		Hispanic Origin can, Maxicen, F Specify:	n? (Specify Puerto Rica	Yas or No- n, atc.)	14. Rad Bla Specif	ca - Amarican ck, Whita, ato	•
		15. Dacadant'	s Educetion		18a. Daced	dant's Usu	al Occu	pation		1	6b. Kind ot B	Whit	
Completed	2	(Specify only highest Elemantary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	Clerk	kind of wi	ork done use retira	du <i>ring</i> most o	f working		Post C	Office	
Be		7. Fethar's Nema (First, Middle, L	ast)					18. Mothar's	Nama (Fir	st, Middle, M	a <i>iden Sum</i> er	m <i>e)</i>	
To		Richard A. Vi	cts					Minn	ie Be	ll Edw	ards		
		19a. Intormant's Name/Ralationsh	p (Type, Print)		19b. Mailir	g Addras	s (Stree	t and Number	or Rural Ro	ute Number,	City or Town	, Stete, Zip Co	ode)
any injury or other traumatic once.	2	Teri VanCamp, Granddaughter Route 5, Box 197 - Harpers Ferry, WV  Oa. Mathod of Disposition  MB Buriai 2 Cramation 3 Ramovai trom State  4 Donation 5 Other (Specify)  Riverview Cemetery  20b. Place of Disposition (Name of cemetery, crematory or other place)  Riverview Cemetery  2/11/2000 Strasbur											
SUCE	1	21. Signature of Funeral Sarvica L	leum-						Harpe	rs Fer	ry, W	Tuneral 7 25425	
an al er	1	23a. Part1. Enter the disease, or o shock, or haart failure. List o mmadiata Causa (Final disease or condition	^		th. Do not ent		de of dy	lng, such es ca	rdiac or res	piretory arras	st,	In	pproximata tervel Batween nsat and Death
		asulting In death)			or es a conseq		:						
line			- b - C		The H			) acelur	e			į	week.
Examiner		Sequentially list conditions, fany, laading to immediate			or as e conseq		:						
		Sequentially list conditions, if any, leading to immediate seusa. Enter Underlying Cause (Disaasa or Injury hat initieted evants	c		entra								54ears.
Medical	1	asulting in death) Last	d	Due to (d	or as a consequ	uenca ot):						1	
clan													
by Physician/M		art II. Other significant condition	s contributing to deal	th but not ras	suiting in the ur	ndarlying	ceusa gi	van in Part I.			B 2 No	ontributa to th 3 ☐ Probab	e cause of death'
Completed b	-									24a. Was an perform	autopsy ed?	avalla	autopsy findings bia prior to lation of cause ath?
Com										1 ☐ Yas	2 No	1 🗆 Y	as No No
Be		5. Was casa rafarrad to madical examiner?						26. Place of	Daath (Ch	eck only one			٧
To		1 Yas 2 No	Hospitel: 1 ☐ inp	patiant 2	ER/Outpatien	3 D	OA Ot	her: 40 Nursi	ng Homa	5 🗆 Rasidan	ce 6 🗆 Oth	nar (Specify)	
	2	7. Manner of Death    Daniel   5 Pending   invastige   invastige	tion	Injury Day Year)	28b. Time of injury	M	28c. Inju Wo 1 [		28d.	Describe how			
Certification:		3 ☐ Suicida 6 ☐ Could no datarmin	ed 288. Piece of	Injury - At h , etc. (Special	ome, tarm, stra	at, factor	y, office		28f. L	ocation (Stre City or Town,	et end Numb State)	per or Rural R	oute Number,
edicai	2	9e. Certifiar (Check only one) Certifying 2 Madical E.	Physician: To the be taminar: On the basi and manna	s of examine	wledge, deeth	occurred astigation	at the ti	me, dete end p opinion, death o	elace, and d occurred at	lue to the ceu tha tima, det	se(s) end me a and piace,	enner es stete and dua to the	e ceuse(s)
completely filled in		9b. Signature and titla of certitier				29	c. Licens	sa number		29d. Data signed (Month, Day, Year)			

State Registrar

FEB 0 9 2000

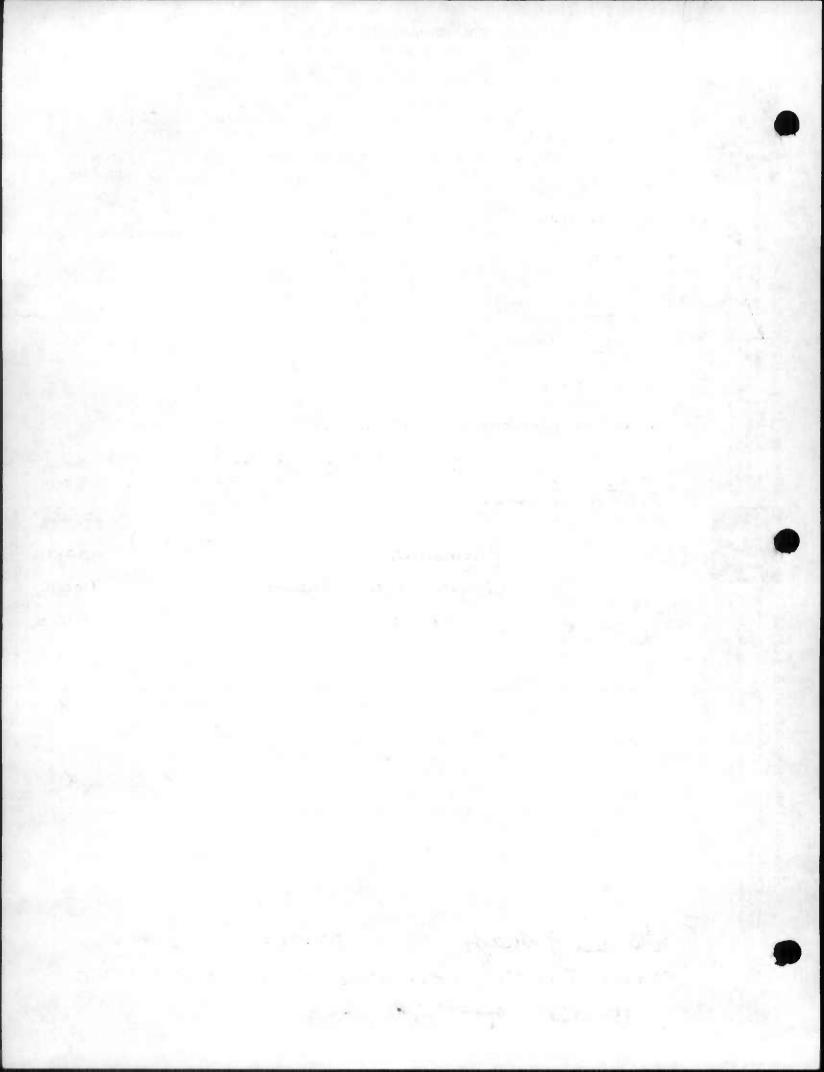
D24365 2-8-0.

30. Noma and addressed person who completed causa of deeth (Itam 23a) (Type, Print)

Manzar J. SHAPI. 368 Mill Street-Itagers Town MO 21740.

31. Data filed (Month, Day, Year)

32. Registrar's Signatura



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day February 1, 2000 4:10 P.M. Harry McLain Ensor 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1)X) M 2□ F 220-16-0679 Yrs. 74 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Dickerson 10a. Street and Number 10f Zio Code 10g. Citizen of What Country? 23030 Mt. Ephraim Rd. 20842 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 M Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dairy Farmer Farming 9 17. Father's Name (First, Middle, Last) 18. Mother'a Neme (First, Middle, Maiden Surname) Harry Ensor, Sr. Martha Luhn 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie Ensor/spouse 23030 Mt. Ephraim Rd. Dickerson, MD 20842 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Monocacy Cemetery Beallsville, MD 21. Signeture of Funeret Service Licensee 22. Name end Address of Fecility Hilton Funeral Home Box 86 Barnesvill Barnesville, 20838 MD Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of): COVO. Sequentielly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was an eutopsy performed? completion of cause of death? 1 Yea 2 No 1 ☐ Yes 2 ☐ No 25. Waa case referred to medical 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

Director

Funeral

à

Completed

Be

2

MD

the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or then any Injury or other traumatic event, the Heider Fraumatic event, the Heider Event e

aitimore. Maryland 21215-0020

Box 68760,

P.O.

Records.

Division of Vital

Examiner that the death certificate be assocuted physician and s the burial-transit Physician/Medical 80 signed by the at þ Completed page 2 Attending Physician: director, Be Certification: To this funeral After death. 4 hours after death

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Menner of Death

125 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1. Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29c. License number D2164

29d. Date signed (Month, Day, Year) FEB. - 2 - 00

30. Name end address of person who completed cause of death (ttem 23a) (Type, Print)

Frederick MD BARAKAT 310

State Registrar

31. Date fited (Month, Day, Year) 32. Registrer's Signeture 0 4 2000

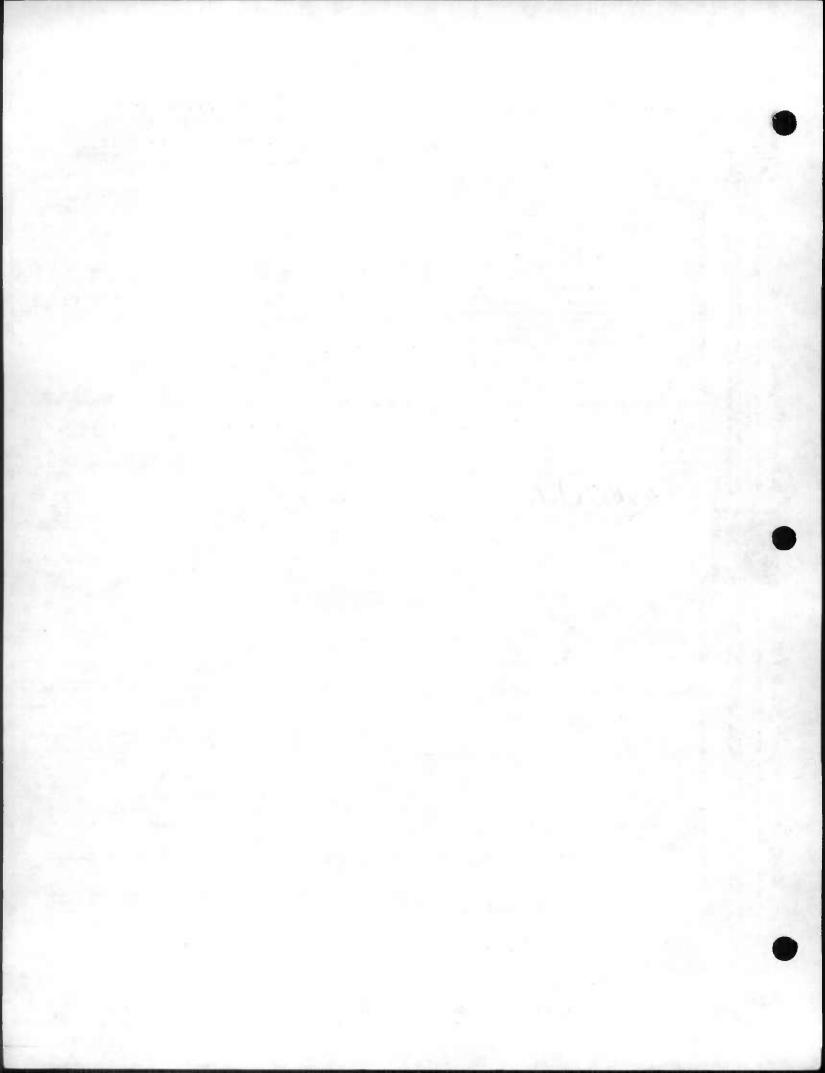
28a. Dete of Injury (Month, Dey Year)

in 24 hours the Funeral Direction by

within 2 To the ş

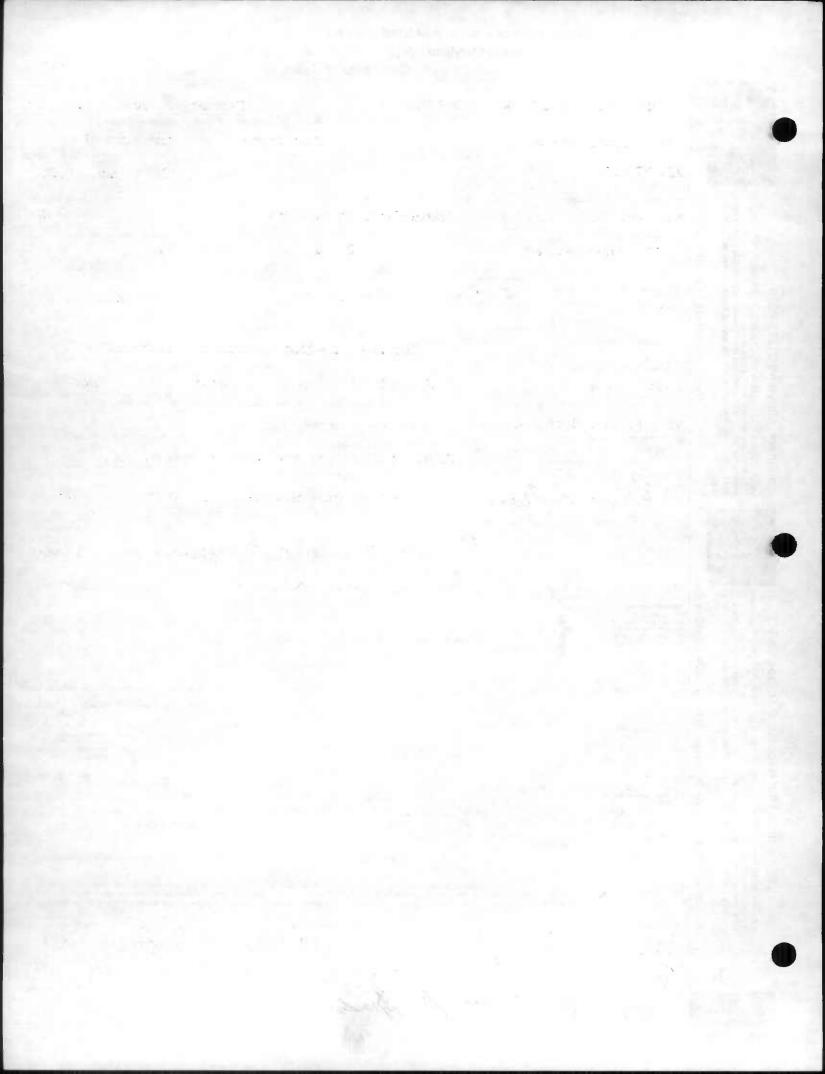
edical

5 Hospital 28b. Time of



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** February 8 MILTON MATTHEW ERHARDT 2000 1:00 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Rose Haven Dover Avenue 5 Social Security Number If Undar 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□ F Months Hours 224 22 8567 103 Director Jan 27, 1897 Wash., D.C. Usual Residence of Decedant the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Rose Haven, North Beach Maryland Anne Arundel Director 10f. Zip Code 10e. Streef and Number 10g, Citizen of What Country? with 20714 7011 Dover Avenue USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerlo Rican, etc.) 12. Was Dacadanf Evar In U,S. Armed Forces? 14. Race - American Indian, 11 Marifal Status Black, White, efc. Yas 2 No 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white by 3 ₩ Widowed 4 Divorced Yaar or Datas: "netural", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) construction plumbing & heating contractor 3 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Mary Erhardt Jane Barr John H 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above Vera E. Blenkiron / daughter 20e. Method of Disposition 20b. Place of Disposition (Name of camatery, crematory or other place) Date 20c. Location - City or Town, Stata Burial 2 □ Cremation 3 □ Removal from State permit. Paga Department o important: If any injury or 2-10-00 4 ☐ Donation 5 ☐ Other (Specify) Wash., D.C. Prospect Hill Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only our cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final 3 mis disease or condition rasulting in death) Examiner Examiner hwvere 3 un Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and bunal-tran certificata be exec Division of Vital Records, P.O. Box 68760, physician Physician/Medical tha Dua to (or as a consequence of): 88 attending usa Por the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior fo 24a. Was an autopsy Completed peen completion of cause of death? page 2 has 20 No 1 Yes 1 Yes 2 No certificate Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Naturel 5 Pending ector: Af investigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a, Certifier (Check only one) Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of cartifier

State Registrar 31. Dete filed (Month, Day, Year) FEB 1 0 2000 32. Registrar's Signatus



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30 RUTH MAY ELLIOTT 1500 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY WICOMICO 2315 HUDSON DRIVE If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 2□ F 77 Yrs 213-12-5777 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2315 Hudson Dr. 21801 USA 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 13. Was Decadent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritei Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Taylor Elizabeth Bennett Taylor 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joanne Miller, Friend 401 E Moss Hill Lane, Salisbury, Md. 21804 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) Mardela Memorial Cem. 2-3-00 Mardela, Md. 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Short Funeral Home, Inc. ellow 13 E. Grove St. Delmar, De. 19940 23a. Part1. Entar tha diseasa, or complications that cause me death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feliure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Ceuse (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequenca of): Due to (or as a consequence of): Due to (or as e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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Hospital or Attending Pt
 124 hours after death.
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To the Hospital within 24 hours a To the Funeral Completely filled

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director

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Box 68760.

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**Physician** 

/Medical

**Examiner** 

**Funerai** 

Director

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The Medical Examiner

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Funeral

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Completed

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72 hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai þ Completed Be 10 Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case refarred to medical 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa Yas 2 No 28c. Injury at Work? Menner of Death 28a. Date of injury (Month, Day Year) 28b. Time of Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

5☐ Residance 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

In = 63

JOHN T. BULKELEY, M.D.

DME D0003599

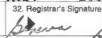
1-31-00

30. Neme and address of person who completed cause of death (item 23e) (Type, Print)

SALISBURY, MD.

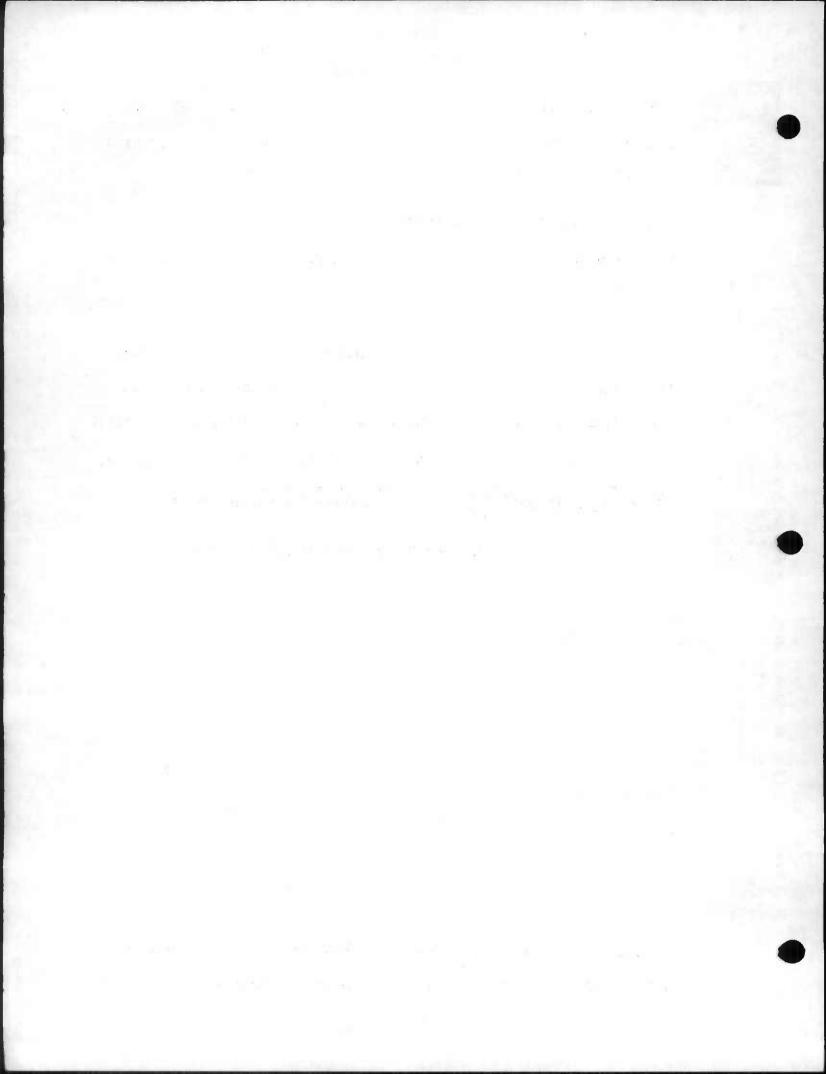
State Registrar

31. Data filed (Month, Day, Year)



Sports

106 MILFORD STREET



# **Physician** /Medical **Examiner Funeral** Director

554 212-12-638

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month CHARLES W. ELLIOTT, JR. January 27, 2000 ocation of Death 0300 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign LAUREL. 1₩ 2□ F 80 212-12-0387 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits DE SUSSEX GEORGETOWN 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 56 BRAMHALL ST. 19947 USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 M Yes 2 No If Yes, Give Year or Dates: 1941 − 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER & OPERATOR MOTEL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be CHARLES W. ELLIOTT, SR. HILDA LYNCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA LEE ELLIOTT - DAUGHTER 56 BRAMHALL ST., GEORGETOWN, DE 19947 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stata cemetery, cremetory or other place)
UNION CEMETERY 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01-30-00 GEORGETOWN, DE 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licanses 22. Name end Address of Facility SHORT FUNERAL SERVICES 416 FEDERAL ST., P.O. BOX 233, MILTON, DE 19968

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

**Physician** /Medical Examiner

The law requires that the deeth certificate be execute

Hospital or Attanding Physician: Direc

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within 24 hours a To the Funeral D completely

Division of Vital Records, P.O. Box 68760.

Immediate Cause (Finel disease or condition resulting in death)

Multiple cerebral em boli 13 days

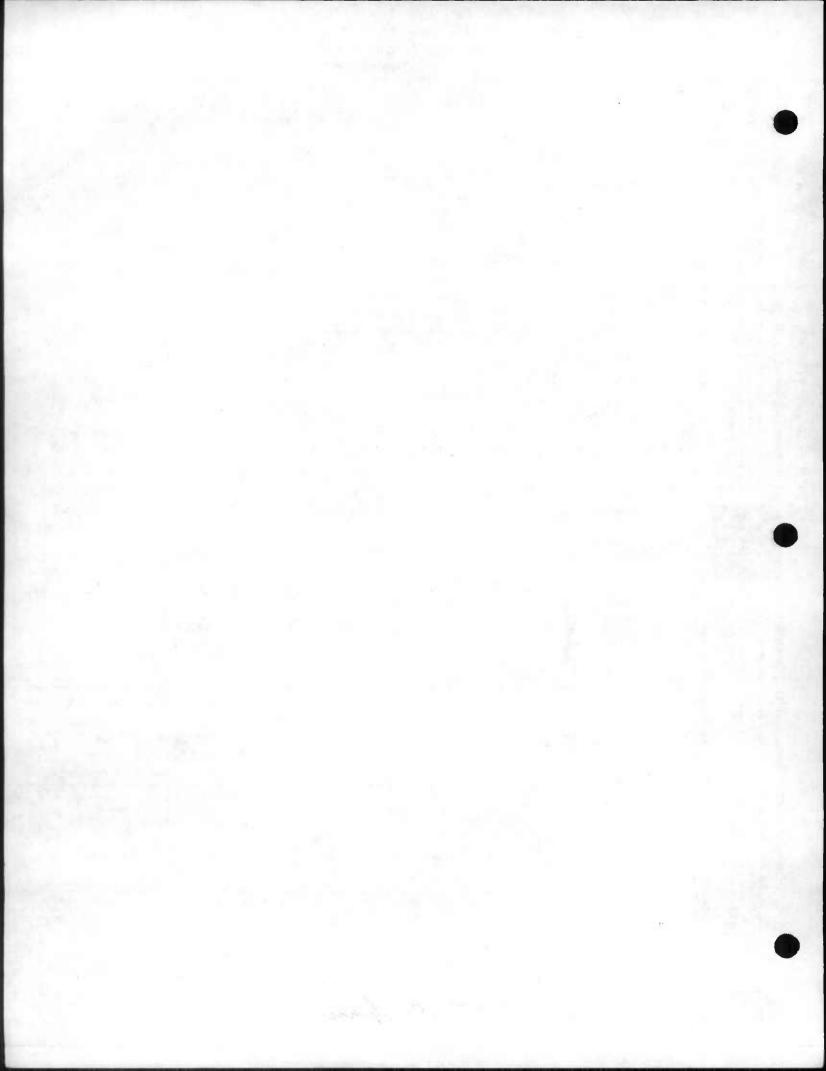
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	Severe		at CABG	Surgery	13 1.648
Part II. Other significant conditions con	tributing to death but not res	sulting In the underlying	cause given in Part I.	23b. Did tobecco use co	ntribute to the cause of death
Chance of	struction for	ime Ni	0000	24e. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical		of war	26. Place of De	eeth (Check only one)	
1 □ Yes 2 ☐ NO	lospitel: 1 1 Impatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residenca 6 ☐ Oth	er (Specify)
27. Menner of Deeth  1 Natural 5 Pending  2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. tnjury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Sulcide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and Numb City or Town, Stete)	er or Rural Route Number,
				e, and due to the cause(s) end ma urred at the time, dete and placa,	
001 01 1 1 111 01 111	A A		0- 11	004 0-4-4	d March Co. March

State Registrar

31. Date filed (Month, Day, Year) IFIEIB 0 1 2000

se of deeth (Item 23a) (Type, Print)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** F. CORR FISS IF NORMAN 2000 /Medical If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RSTREVILLA BIBA VE Wicomico If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10M 20 F -28-063 Director 254 - 21 TROKS Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BIDALVE Director 1 Yes 2 No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3084 JESTELL 54 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien Bleck, White, etc. 1 Yes 2 N 1 ☐ Yes 2 ☐ No Specify À 3 ☐ Widowed 4 ☐ Divorced AMRLICAN 120-Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Look SCEAN CH permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked other any injury or other traumatic event ones. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 8 Eldre 5. Blank KING nant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JESTELVILL R EldR ORIS 20a. Method of Disposition 20b. Place of Disposition (Name of Diete 20c. Location · City or Town, State etery, crematory or other place 1 Durial 2 ☐ Cremetion 3 Removal from State JESTRIGHTE 000 ma 4 ☐ Donation 5 ☐ Other (Specify) RMRIAL oral Service Licenses 22. Name and Address of F acility 91 WRST md: BENN 12 se, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respirator. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Mamour disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Otatural 2 Accident 5 Pending investigation

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altimore, Maryland 21215-0020

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

6 Could not be 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28b. Time of Injury

1 Yes 2 No

28l. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier remod

FEB 01

29c. License number

29d. Date signed (Month, Dey, Year) 1/3/ 60

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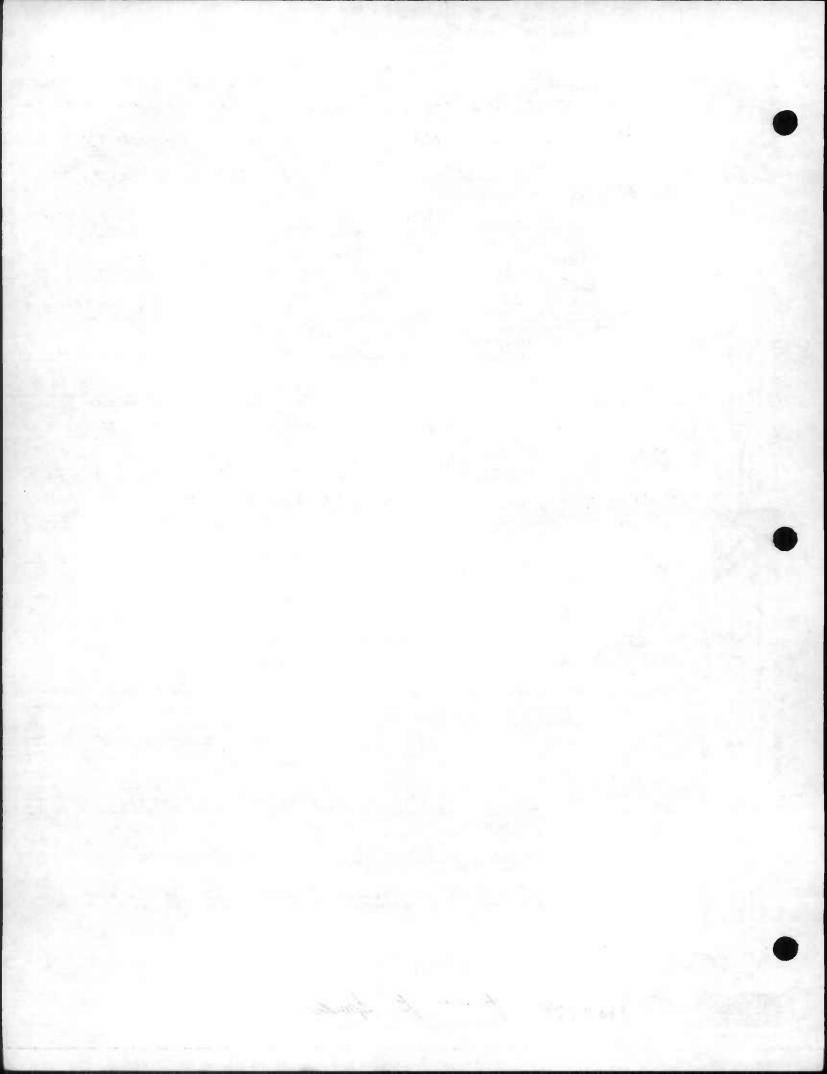
person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad GRASSO 145 31. Date liled (Month, Day, Year)

32. Registrar's Signature 2000

SAUSBURY CARROLL ST

State Registrar

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- 10	28 5	1 Never Marriad 2 Married	Armed Forces? 1 → Yas 2 → N		If Yas, specify Cube	en, Mexican	gin? (Specify Yes or No , Puerto Rican, atc.)	Bia	ck, White, e	tc.
21215-0020 d within 72 hours effer	"natural", or items 23a or 28a-f show adical Examines must be northed at leted by Funeral Director	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes 2X No	Specify:		Specif	WHI'	TE
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an d be	Mental Hygiene. srked other thereit event, treit To Be Comp	CLYDE D. ELRI	CK			HAI	RRIET E.	KALBAU	GH	
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68760, flicete be ex	hysic the t	that initiated events resulting in death) Last		Due to (or as a conse	quenca of):					
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. 5	d by the attendeteched for us	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause give	ven in Part I	. 23b. Did	tobacco uae co	ontribute to	the cause of death?
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Atte	rs efter deeth.  el Director: After t led in by the funers  Certification:	3 ☐ Suicide 6 ☐ Could not b	280. Place of Inju	ry - At home, farm, s	treet, factory, office		28f. Location	(Street end Num	ber or Rural	Route Number,
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운	n 24 hou re Fune pletely fil edical	(Check only 2 Medical Examone)	miner: On the basis of and mannar sia		nvestigation, in my	opinion, dea	th occurred at the time	, date and placa,	, and due to	tha cause(s)
oth	omp Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, E	Day, Year)
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1		Robustiano J. 31. Dete filed (Month, Day, Year)		D = 500 r's Signature	Memorial	avenu	e, cumberl	and, MD	2 150	16
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			707	~	Jan Jan	-3/				

Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** FEBRUARY 3 2000 12:36 PM Ruth Teresa Eisel /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ailegany Sacred Heart Hospital Cumberland or If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□M 20 F Months Yrs. Director 214-14-7827 Maryland 27-Sep-21 Usual Residence of Decedent the Manylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director Maryland Allegany frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 170 Frost Avenue Funeral 14. Race - American Indian, deeth 21532-12. Was Decedent Ever in U,S. Armed Forces?-1 ☐ Yes 2 Ø No If Yes, Give/ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 20 No Specify: 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced White Completed h and Mental Hygiene.
7 is marked other than "natur traumatic avent, m. M. o. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **Unemployment Division** 12 State Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt ment of Health and Mental Hant: If them 27 is marked oth jury or other traumatic avent Be Walter Patterson Mary Miller 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stanley Eisel
20a. Method of Disposition Maryland 21532husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or poce. 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 05-Feb-00 Frostburg, Maryland 21. Signature of Funeral Service Line 22. Name and Address of Facility MARI Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Massive MI Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted iclan end burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Due to (or as e consequence of): 86 980 signed by the atte Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Vaa 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? pege 2 has 2 No 1 Yas 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 20 No Certification: To 2 ER/Outpatient 3 DOA After this uneral 27. Manner of Death
1 W Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 24 hours after deeth. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edical completaly (Check only one) To the F within 2 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) **FEBRUARY** 2000 0 npleted cause of death (Item 23a) (Type, Print) This Terry E. Williams, M.D., Memorial Hospital Medical Building, Cumberland, Maryland 21502

DHMH 16 Ray 6/95

State Registrar 2000 (Page )

32. Registrar's Signature

Puth Tereso Eucl

Allegany Combedand Socied Health polital 18 214-14-7827 Maryland 27-Sep- 1 Allegany frostburg Maryland 179 Frost Avenue U.S.A. 21532. SHIP IT STEELS TO THE Unemployment Division 12 Waller Patterson Mary Miller Maryland 21532-Frosiburg Grina La tagra (il bridging! Stanley Esel Prostburg Mentage Park 05-Feb-00 frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Terry E. Williams: M.D., Memorial Hospital Medical Building. Crimbertand. Maryland 21502

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#### Ple

	Please	Type or Prin									ble.	
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	SERGIO	DANIEL	FUEN'	TES					Month FEB	Dey 2 C	Year	9:40am
4a Facility Nam	ne (If not institution, g	ive street and number)			17.		4b. City, To	wn, or L	ocation of Death	4c. County		J. 40am
SHADY	GROVE AI	OVENTIST H	OSPI	TAL			ROCK	VIL	LE	TOM	GOM	ERY
5. Social Securi	ty Number 6.	Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under Months	Pays 23	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey Jan 1	Year)	9. Birth	place (Stete or Foreign htry) MD
Usual Residenc	e of Decedent				- 1 1 1 1							
10a. State	10b. County		10c. City, To									10d. Inside City Limits
MD	Monto	omery	Ro	ckvi	11e							1 ☐ Yes 2 No
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A	us  Married 2 Married  Id 4 Divorced	12. Wes Decedent E Armed Forces? 1  Yes 2 N If Yes, Give		H	Yes, spe	cify Cub	en, Mexican	, Puerto	Salvad	Blad	ck, White,	
3 LI 11100110	15. Decedent's E	Year or Dates:	11	6a. Deced	ent's Usu	al Occur	ation	-		16b. Kind of Br	usiness/In	dustry
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	Fuentes	/mother	· · · · ·				g De	w L				4D 21702
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21. Signature of	Funeral Service Llo	onsog .		H	ilto	n F	ss of Fecilit	a1				
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Immediate Cau disease or cond resulting in deal	dition	. Extre	ne	Re	ma	fur	ity			. 37		23 days
		b. Severe	gvac Que to (or as	le [	V /	trai	rentri	cul	ar Hem	orrhag	e	17 days
if any, leading to ceuse. Enter U Cause (Disease that initiate deal	o immediate indertying a or injury ents	o. Severe	ue to (byas	a conseque	Leu Leu	Ko	male	icio	·		1	17 days.
resulting in deal	un, Last	a. Post H	emor	rhag	rie f	tyo	dro ce	pho	alus			15 days
Part II. Other sig	gnificant conditions	contributing to death but	not resulting	g in the un	iderlying o	ause giv	ven in Part I			es 2 No		o the cause of death
									24a. Was e		84	fere autopsy findings vailable prior to ompletion of cause death?

**Physician** /Medical Examiner

To the Hospital or Atlanding Physician: The law requires that the death carificate be executed within 24 hours after death.

To the Funeral Director: After this carificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burishransit

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Empirer must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant cond

Director

Funeral

Completed by

Be

Physician

/Medical

Examiner

**Funeral** Director

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

NIGAM

31. Date filed (Month, Day, Year)

Neunatolog

2000 Registra's Signature

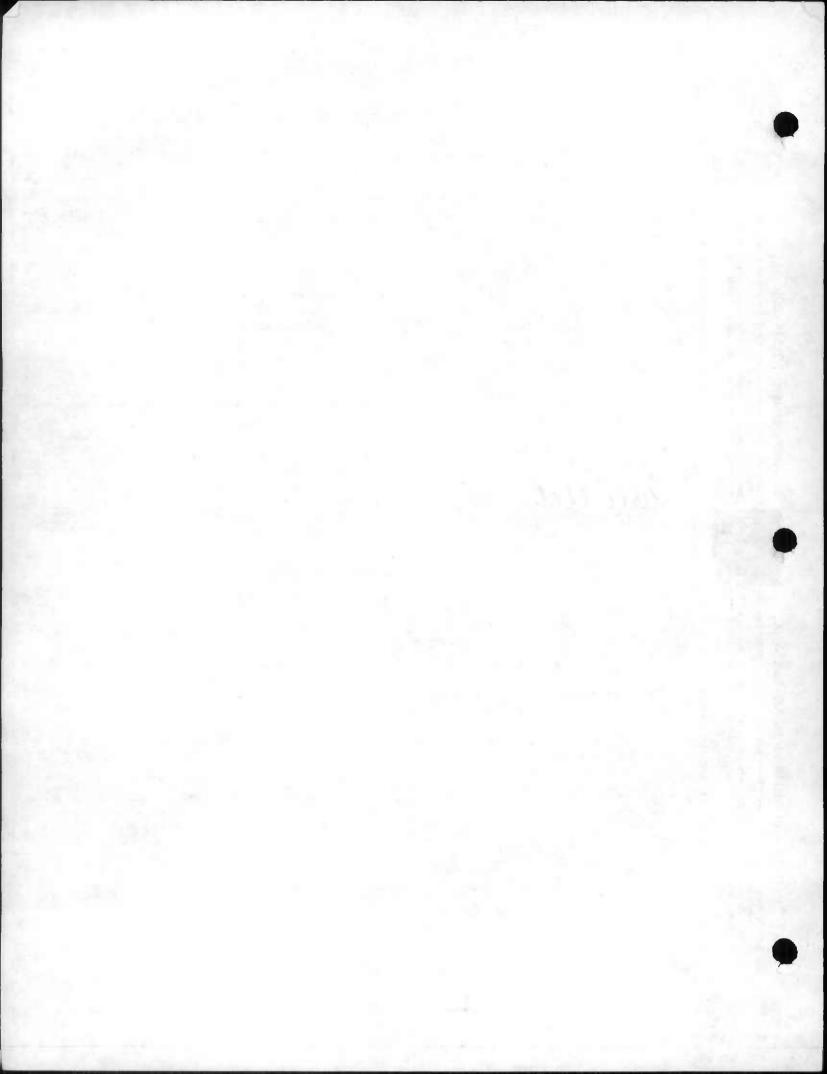
Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1□Yes 2□No	1 □ Yas 2 □ No

25. Was case referred to n examiner? 1 Yes 2 No		lospital: 1 Dinpatient 2	] ER/Outpatient	ع ا	Othor	Here FD Positions & DOtton (Specific)
27. Manner of Death 1 Different 5  2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury et Work? 1 Yes 2 No	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
	Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, streety)	et, fect	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

ady Grove Adventist

29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examinetion and manner stated.	dge, deeth occurred et the time, date end plece, end and/or investigation, in my opinion, deeth occurred e	due to the cause(s) and manner as stated. It the time, date end place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

State Registrar



**Physician** /Medical Examiner

as the burial-trar

attending physician

urs after or Attending Physician: The lew require ours after death.

werel Director: After this certificate has been signified in by the funeral director, page 2 should it filled in by the funeral director, page 2 should

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

The lew requires that the death certificate be executed

Box 68760.

P.O.

of Vital Records.

Division

Onset and Death CIRRHOSIS AND DILATED CARDIOMYOPATHY Due to (or as a consequence of) Due to (or as e consequence of) Due to (or as a consequence of).

Immediete Cause (Finel disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 ☒ Residence 6 □ Other (Specify) 2 1 TYes 2 □ No Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) JANUARY 30,2000

3. Time of Death

0008

Wisc.

10d. Inside City Limits

white

20732

Approximate Interval Between

1 Yes XIX No

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

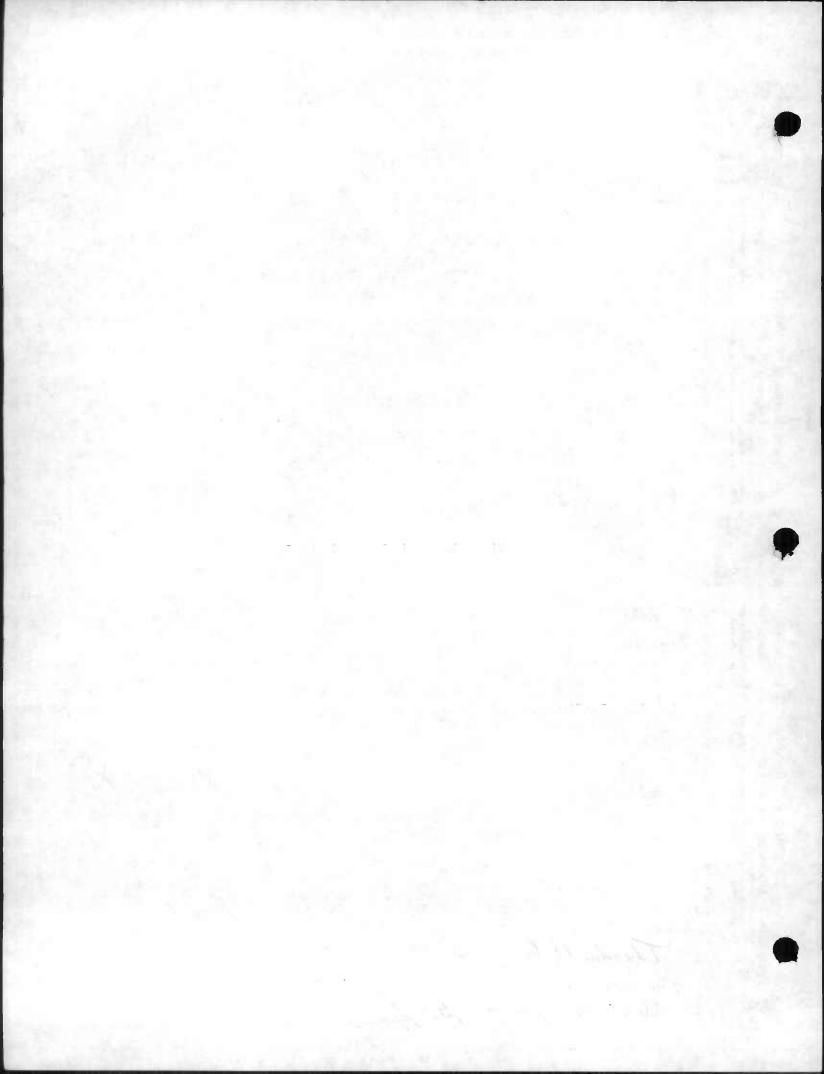
HEODORE M.K.

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) FEB 0 4 2000 32. Registrar's Signature

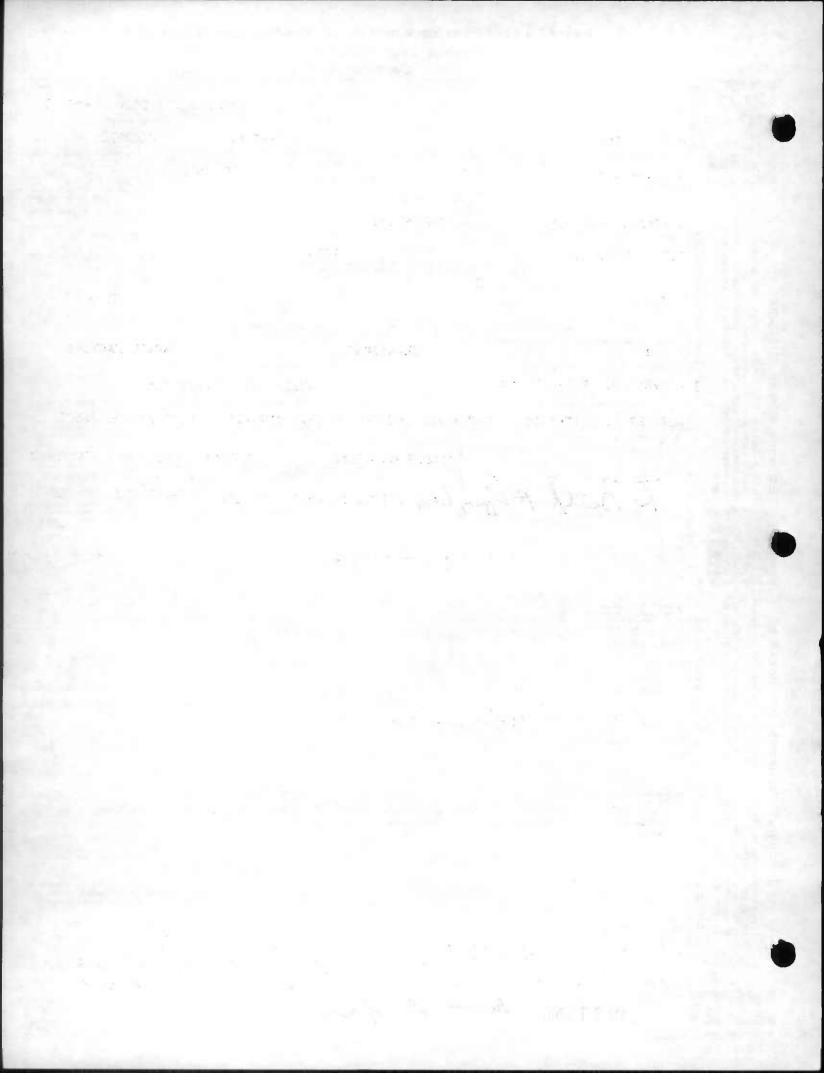
DHMH 16 Rev 6/95

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			cedent's Name	(First, Middle, L	ast)								2. Dete of Deeth		Veer	3. Time of Death
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	/Medica Examine	to Fe		not Institution, g		umber)					4b. City, To	wn, or Lo	ocation of Deeth	4c. County		
	Examine		E. VI	NE ST.							SAT	LISB	URY	WI	COMIC	00
	Funeral		lel Security N	umber 6.	Sex 37	7. Age	(In yrs. last bir	thday)	If Under		If Under	24 Hrs.	8. Date of Birth (Month, Dey,			plece (Stete or Foreign
	Director		-16-85	36	1□M 2ÅF	7	77	Yrs.	Months	Deys	Hours	Min.	DEC. 20,	1922	MAR	YLAND
	show dat	10a. S		10b. County			10c. City, Tow	n or Loc	ation						1	10d. Inside City Limits 1 ∑ Yes 2 □ No
	M et al	MAR	YLAND	WICOMIC	0		SALI	SBUE	T							
	ith th	10e. S	treet and Nun	nber					10f. Zip				10	g. Citizen of \		ntry?
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Ö	2 ho			15. Decedent's E	ducation		16e.	Decede	ent's Usua	d Occup	pation		10	6b. Kind of B	usiness/in	dustry
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		23e. F	Part1. Enter th	e disease, or cor	nplications thet	Dused (	he death. Do	not ente					or respiretory erres	st,		Approximate
	Physician		snock, or near	t failure. List oni	one cause on	eech line	ð.								i	Interval Between Onset and Death
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s, P.O	is that the death certined by the attending a detached for use a Warlelan/M		ple	uve,	1 et	fer	ren	~					1 🗆 Yee	2 D-N6	3 □ Pro	bably 4 Unknown
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>	hystcian: The innit certificate he director, page		aminer? ☐ Yes 2 <b>2</b> 1		Hospital:	Inpatien	t 2 ER/Ou	tnationt	3□ DC	A Ott	hor		me 5 Desiden		er (Speci	(fv)
on or	Attending Physician: or death. ector: After this certific by the funeral director, liffication: To Be (		enner of Death	5 Pending	28a. Date (Mor		28b.	Time of njury		8c. Inju Wo			28d. Describe hov			<i>"</i>
Division	death death tor:	3	☐ Accident ☐ Suicide	Investigation	De See Blac	o of late	At home 4:				2		28f. Location (Stre	aat and Alumi	her or Dire	al Poute Number
2	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	4[	Homicide	determine	build	ding, etc.	y - At home, fe (Specify)	irm, stre	et, factory	, onice			City or Town,		or non	al House Number,
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	Vithin To the comp		ignature end	title of certifier					290	Licens	se number		29	d. Dete signe	d (Month,	Dey, Year)
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	State Registrar	JI, Da		97200		Leve	~ L	1	Ana	N	,					



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 25,2000 1:15 PM **FOOKS** VIRGINIA January /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year if Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□ M 25 F Yrs. 72 September 25,1927 Maryland 216-16-7529 Director Usual Residence of Decadent the Maryland 10d. Inside City Limits 10e. State 10b. County 10c. City. Town or Location notified at 1X Yes 2 □ No Berlin Directo Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with th and Mental Hygiene. 7 is marked other than "natural", or frema 23a or traumatic event, an Wood and Examples and the standard or the st 304 Williams Street 21811 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Biack, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3K Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be t Department of Health and Mental t Important: If Item 27 is marked of any Injury or other traumatic eve Rose Alexander Edward James Larmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Tingle Rd., Berlin, MD 21811 Michael W. Fooks/Son 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cramation 3 ☐ Removal from State 1/27/00 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee Kuth R. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or compileations that causad the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical ancreatitis Examiner Due to (or es a consequenca of) Examiner Centre Failus physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Depsis Physician/Medicai Dua to (or as e consequanca of) 916-16-7529 attending for use as Swere / resp. Failure ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac Severa AremiA by 24b. Were autopsy findings evailable prior to completion of causa of deeth? 24a. Wes en autopsy performed? Completed s certificate has b director, Be 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: / d in by the f 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

Division of Vital Records, P.O. Box 68760

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Bpieed

or Attanding Physician: within 24 hours aft To the Funeral Dis completely filled in Hospital To the

101 000 State Registrar

edical

4 Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

JAN 2 7 2000

100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and menner stated. 29c. Licansa number

100537

29d. Data signed (Month, Dey, Year) 2000 25

Berlin, mo

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

JEAFRY MAT
31. Date filed (Month, Day, Year) 9714 Healthway MATEUNI DU DRIVE

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

n					001	modio	of Death		Reg. No.		
	1. Decedent'a Nama (Firs	st, Middle, Las	st)					2. Data of De Month	ath Day	Year 3.	Tima of Death
	Doris		Faye	100	Fr	anz		January			4:25
er	4a Facility Nama (If not in	nstitution, give	a street and number)				4b. City, Town, or				
ı	Memorial Ho	spital					Cumber1a	nd	Alleg	anv	
	5. Social Security Number	6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Under 1 You Months De		8. Data of Bir		9. Birthplace	(State or Foreig
-	236-04-4079 Usual Residence of Dece		□M 2⊠F	79	Yrs.	WOUNTS DE	lys Hours Hill	March 2	6,1920	West V	irginia
	10a. Stata 10b.	County		10c. City,	Town or Loc	cation					nside City Limit
-	WV G:	rant		M	aysvi	11e				1	□Yas 2⊠N
1	10e. Street and Number					10f. Zip Coo	le		10g. Citizen of V	What Country?	
-	HC 72, B	ox 25				26833	3		USA		
	11. Marital Status		12. Was Decedent Armed Forces?		13. W	Vas Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yas or No	- 14. Rac	e - Amarican In ck, Whita, atc.	dian,
	1 Never Married 2 3 Widowed 4 □ D	-11-11-11-1	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates;		100		No Specify:	10 7 110011, 0101,	Specify		
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	Elementary/Secondary	(0-12)	College (1-4or !	5+)		Homemal			T.	omemake	r
-	17. Father'a Name (First,	Middle, Last)				nomema)		ma (First, Middle,			
										· .	
+	Ira  19a. Informant's Name/Re	Ree			100-14-71	- Add /0-	A1ma reet and Number or R	Odes		McDonal	
Н										State, Zip Cool	9)
Н	Floyd M. Fr		r. Husbai			, BOX a	25 Maysvil	Data Data		Ch. or T	No.
1	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crer		Removal from State	Cert	netery, crem	natory or other	place)	Data	20c. Location -	City or Town, S	otata
	4 Donation 5 0	Other (Specify	)	Mays	sville	e, Ceme	tery Jan	31,200	) Maysvi	.11e, WV	7
	21. Signature of Funeral S	Service Licen	see /				Idress of Facility	1 77	72.4		
	A.T.	(1	1/11.				-Adams Fun atur St. C			21502	
+	23a. Part1. Enter the dise shock, or heart feilur	ease, or comp	olications that caused	the death.						App	roximata
	shock, or heart fellul	ra. List only	one cause on each li	ne.							rval Between et and Death
	Immediata Cause (Final										
	disease or condition resulting in death)		Aspira							1	1 hour
			D	Due to (or a			0	1		1	4.1.
			b. Recurre				Gastropat	пу		1	month
i	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ns, nta		Due to (or a	s a consequ	uence or):					
1	Cause (Disease or injury that initiated events	~	c. Chronic							ye	ars
F	resulting in death) Last			Due to (or as	s a consequ	ience of):				1	
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F	Part It, Other significant of	conditions co		ut not resulti	ng in the un	derlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to the	cause of deat
F			ontributing to death b					10	tobacco use co Yaa 2 <sup>125</sup> No		
-	Part II. Other significant of		ontributing to death b					isease <sup>1</sup>	Yaa 2⊠No	3 Probably	4 🗆 Unkno
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Doris Franz

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State of Maryland / Department of Health and Mental Hygiene 06240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DONALD OWEN FULLER F E B 5 2000 1:25 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 14304 CRESAP MILL RUN ROAD OLDTOWN ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10XM 20 F Yrs. 215-20-5925 Director SEPT 18,1926 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits rs 23a or 28a-f show must be notified at 1 Yes 2 No Directo MARYLAND ALLEGANY OLDTOWN 10e. Street and Number 10a. Citizen of What Country? 10f. Zin Code 14304 CRESAP MILL RUN ROAD 21555 USA Funeral Berra Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 X Yes 2 □ No
If Yes, Give
Yeer or Detes: WW II 1 Never Married 2 Merried 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 filed within Elementery/Secondery (0-12) College (1-4or 5+) AUTO MECHANIC AUTOMOTIVE 10 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H lant If Hem 27 is marked off fury or other traumatic ever Be LEONARD FULLER 2 CLAIRE UNKNOWN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) CUMBERLAND, MD 2150
Date | 20c. Location - City or Town, State MARIE RAYNOR/DAUGHTER CLEMENT ST. W. MD 21502 20b. Plece of Disposition (Name of comatery, crematory or other place)
ROCKY GAP VETERANS 20a. Method of Disposition FEB ₩D\Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 FLINTSTONE, MD Signature of Funerel Service Licenses 22. Neme end Address of Fecility HAFER CHAPEL OF THE HILLS MORTUARY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21502 Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel ATHEROSCLEROTIC HEART DISEASE UNKNOWN diseese or condition resulting in death) Examiner Dua to (or es a consequence of): The law requires that the death certificate be executed the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In death) Last pue Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): USB BS P.O. ate hes been signed by the page 2 should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUNknown HYPERTENSION Records, þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate of Vital or Attending Physician: 25. Was casa raferred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Yes 2□ No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division After Natural 5 Pending ie Hospital or Attending n 24 hours after death. Ne Funeral Director; Afti 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and manner as stated.

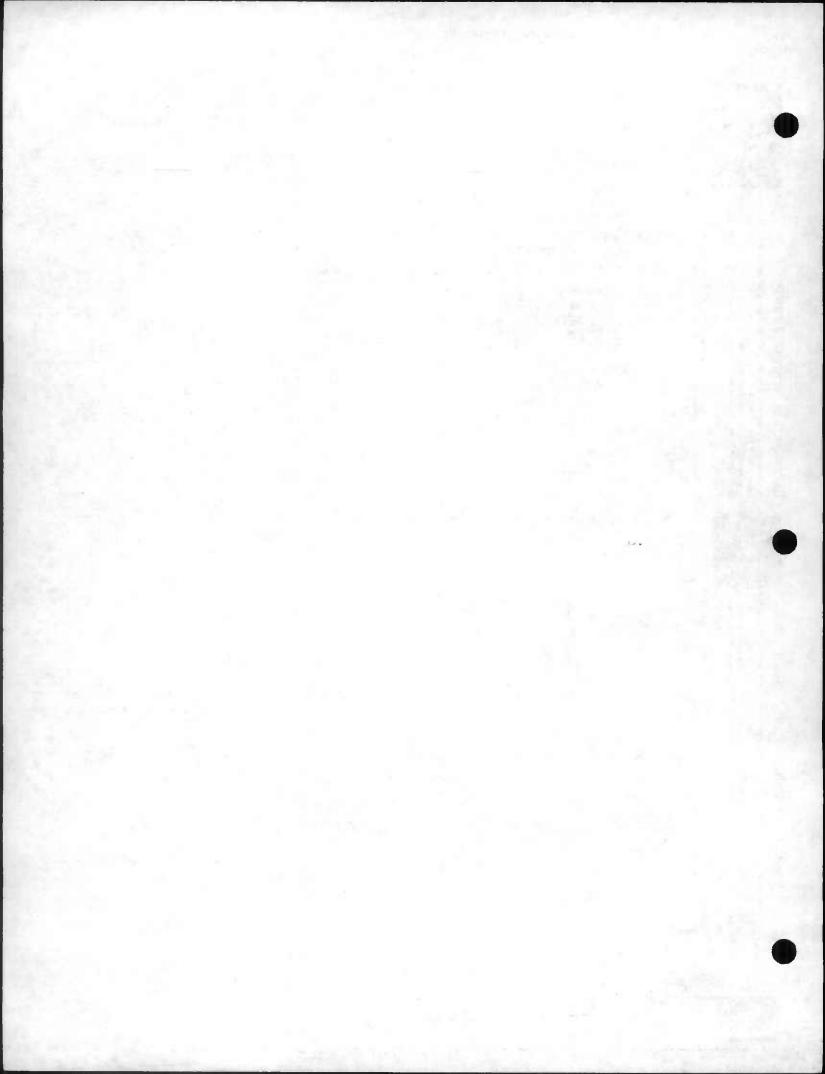
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical To the Hosp within 24 ho To the Fund completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and titla of certified D09157 FEBRUARY 5,2000 6 completed cause of death (Item 23a) (Type, Print) 30. Name end addrass of person who 760 PAULSNOW 124 W 3RD STREET, CUMBERLAND, MD 21502 FEB "0" 7° 2000 32. Registrar's Signature Oaker Registrar

FEB 0 7 2007 James John Street

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UNIVERSITY OF MARYLAND MEDICAL STATE OF MARY	ors. last birthday) 51 Yrs.  City, Town or Lo ALTIMOE	Months Days  ocation  R E	BALTIMOR	E		9. Birthpl	non (State on Face)
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THOMAS GREGORY, SR.  19e. Informent's Neme/Relationship (Type, Print) PATRICIA GREGORY (WIFE)  20e. Method of Disposition 1 Burial 2 Gremation 3 Removal from State 4 Donetion 5 Other (Specific) 21. Signeture of Funerel Service Lieuwers ellure. List only one ceuse on each line.  23a. Part. Enter the disease. In complications that caused the condition resulting in death)  23a. Part. Enter the disease. In complications that caused the condition resulting in death)  25a. Part. Enter the disease in complications that caused the condition resulting in death)  25a. Part. Enter the disease in complications that caused the condition resulting in death)  25a. Part. Enter the disease in complications that caused the condition resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25a. Part. Enter the disease in complications that caused the conditions resulting in death)  25b. Wes case referred to medical exeminer?  25c.		1□Yes 2₺No			Bleck	- America k, White, a BLAC	itc.
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Suicide  4 Homicide  4 Homicide  4 Homicide  28e. Plece of Injury - Journal of the determined building, etc. (Sp	r) 28b. Time of Injury		ury et ork? ] Yes 2 No	28d. Describe	now injury occurr	60	
29e. Certifier 1 Certifying Physician: To the best of my	t home, ferm, str ecify)	treet, fectory, office		28f. Location ( City or To	Street end Numb wn, Stete)	er or Rure	Route Number,
29e. Certifier  (Check only one)  29e. Certifying Physician: To the best of my check only one)  29m Medical Examiner: On the basis of exemend manner steted.  29b. Signeture and title of cartifier	knowledge, deett inetion end/or in	th occurred et the nvestigation, in my	time, dete and pleca, opinion, deeth occur	and due to the red et the time,	ceuse(s) and ma dete end pleca,	nner es st end due to	ated. the cause(s)
30. Name and address of person who completed cause of death (		O.,	C.M.E.		JANUAR	Y 25,	
State Registrar  State Registrar	igneture		spark	, Maryla	and 2120	1	



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death +ANSATO 1030 Am **Physician** GILMORE ROBURT 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) June 28 1 Birthplaca (Stete or Foreign Country) **Funeral** 150 M 2□ F Hours 214-36-1997 60 1939 Director Wash., Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2TA No Director MD Montgomery Poolesville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21315 Whites Ferry Road 20837 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 No "natural", or Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 ai Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 9 Business owner Trucking 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Be Francis Issac Gilmore Calista Bell Dodson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20837 19e. Informent's Neme/Reletionship (Type, Print) Mary E. Gilmore/spouse 21315 Whites Ferry Rd. Poolesville, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State permit. Page Department of Important: If any injury or page. 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery Rockville, MD 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Hilton Funeral Home Barnesville, Box 86 MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** /Medical (PNEUMONIA Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner INFLUENCE sician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLIUS, AMENDOCUENOTIC CARDIDVASCULAR Records, Completed by should be 24b. Were autopsy findings aveilable prior to completion of cause of death? DIKEASE, EMBONIC ALCOHOLISM 24a. Was en autopsy performed? 2 No 1 Yes 200 No Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Neturel 2 Accident s after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner stated. edicai \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 ( OM8 015236 JANUARY 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIKE, ROCKVIUS MO 2085 2

**DHMH 16 Rev 6/95** 

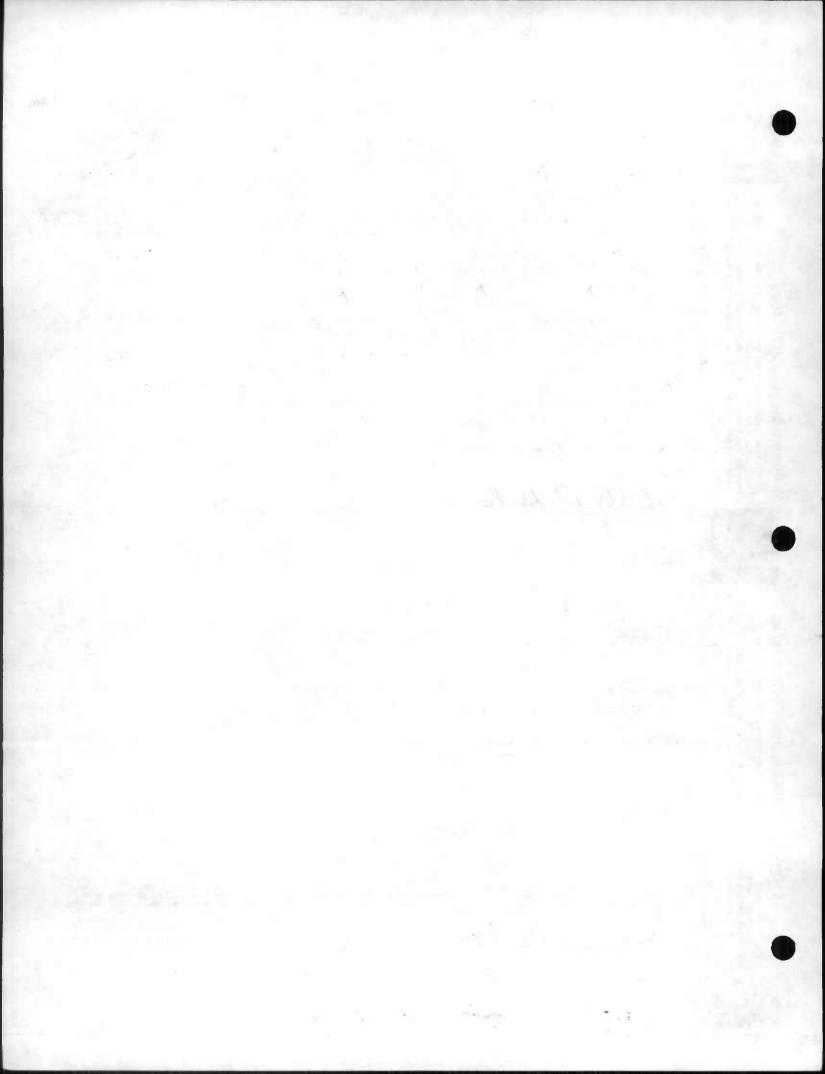
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31. Dete filed (Month, Day, Year)

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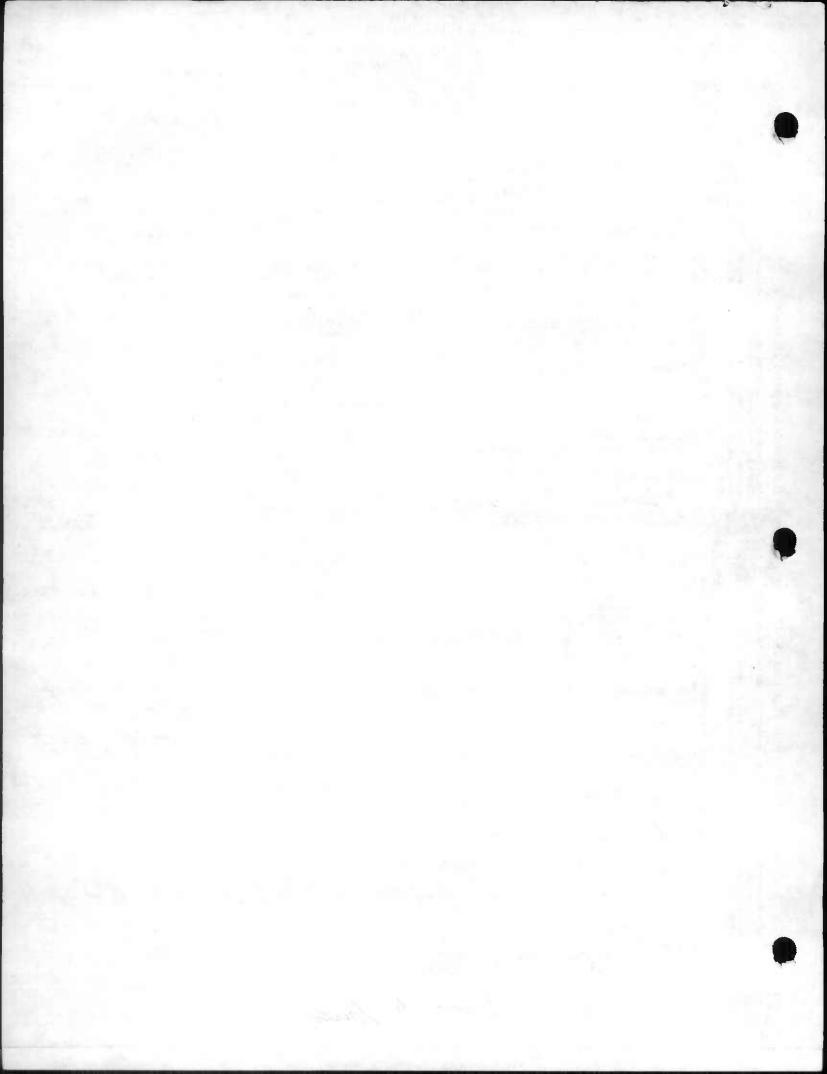
32. Begistrer's Signature



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State of Maryland / Department of Health and Mental Hygiene 0 624

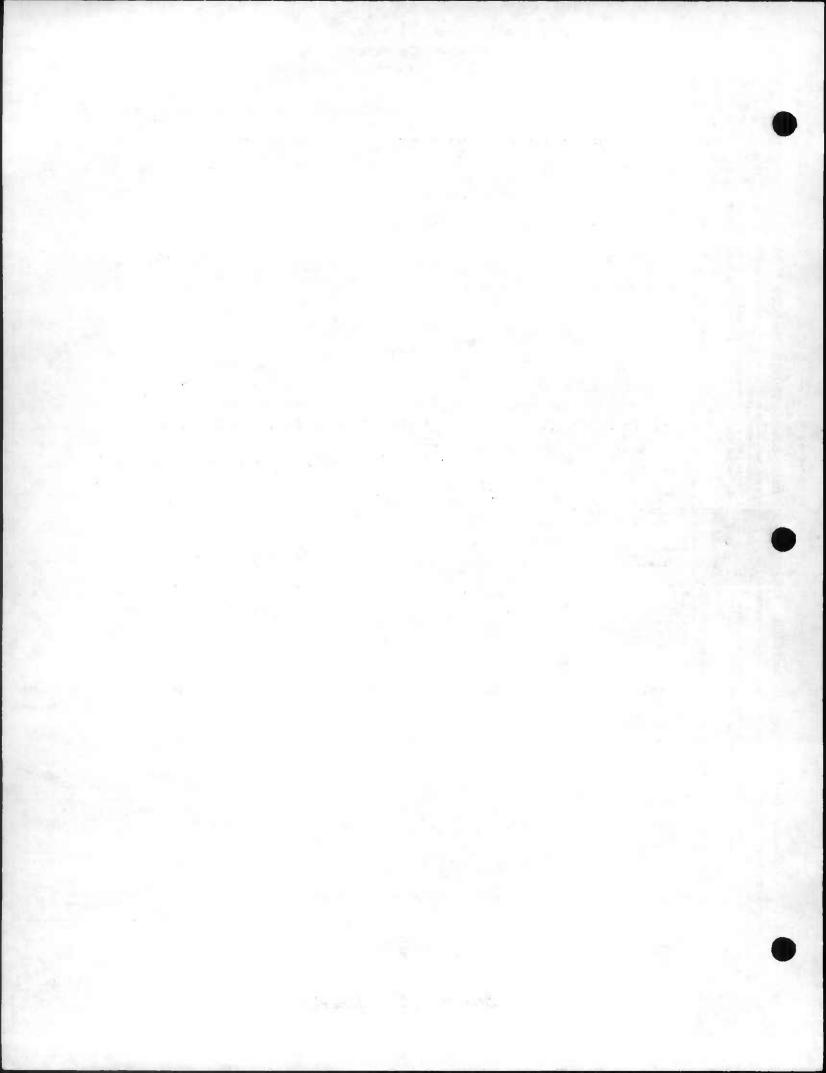
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/Medical Examiner	4a Facility Nama (If not institution, giva	street and number)	7 (		4b. City, Town, or			of Death	
<u> </u>	5. Social Security Number 6. Sec	hine Hos	p, a	If Under 1 Yaar	1000	LOPE S. I a Date of Bir			COUNTY laca (Stata or Foraign
Funeral Director	218-48-2549	M 2MF 53	Yrs.	Months Days			1946	MARY.	try)
P	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
with the Maryland a or 28a-f ahow be notified at	DELAWARE SUSSEX		LSBORO						1 ☐ Yas 2 🛣 No
E 23 B	10e. Street and Number 22 LINGO ESTATES			10f. Zip Code 19966			10g. Citizen of V	What Count	ry?
Dy by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 IK No If Yes, Giva Year or Datas:	11	Vas Decedent of Yas, specify Cut	Hispanlc Origin? ( pan, Mexican, Pua Specify:	Specify Yas or No rto Rican, atc.)	Blac	e - Amarica ck, Whita, a v: WHI	atc.
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Magnith and 2 in 172 is	19a. Informant's Name/Ralationship (Ty WILLIAM L. GREEN	pe, Print) - HUSBAND		-	tand Number or F				Code)
F 2252	20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	lemoval from State	ematery, crem	sition (Nama of natory or other pla VET . MEM		Data 2/9/00	20c. Location -		
Baltim permit. Par Department important: any injury once.	21. Signature of Funeral Service License	11st		Nama and Addr	ass of Facility ERAL HOM	E, INC.,	MILLSB	ORO,	DE 19966
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Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	Multip	r as a conseq	ragar	, Pai	hre			Onset and Death
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Box eath cart attending for usa			- 4					1	
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= F 4 4 0						1 🗆	Yas 20 No	10	Yas 21 No
Vital Filesians The cardificate cardificate of Be Co	25. Was casa refarred to medicel examiner?	lo a chali				eath (Check only	one)		
0 5 55	1 Yas 2 No  27. Manger of Death 1 Natural 5 Pending	28a. Data of Injury (Month, Day Year)	ER/Outpatien 28b. Tima of Injury	t 3□ DOA O		Homa 5 ☐ Res 28d. Describe	dence 6 Oth		0
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20.252	29a. Certifier 1 Certifying Physic (Check only 2 Medical Example	sician: To the best of my knowner: On the basis of axaminat	wledge, death	occurred at tha t	ime, date and plac	e, and due to the	cause(s) and mi	annar as at	ated.
To the Hose within 24 in To the Fun completely	one)	and manner stated.				at the time.			
OT OF OF	296. Signature and use of devision	Imanbek	AIN	DE	se number	00	29d. Date signe	and anount, I	4 2000
6+ 6	30. Name and address to person who co	inplifted cause of death (flerr	23a) (Type, I	Print)	Hard	: 1 lm	Colu	wisher	M 21045
State Registrar	31. Date filed (Month, Day, Year) FEB 0 7 200	32. Redistrar's Signa	tura &.	don	//	NAO P.V	COW	The sale	11 10 20 11



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State of Maryland / Department of Health and Mental Hygiene 0 6 2 1 1

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ion emation 3 □F ]Other <i>(Specify)</i>		1	FATRWAY	Y T.AN	E. OCEAN	PINES. M	D 2181	1			
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21. Signature of Funeral Service Licenses 22. Name and Address of Facility											
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<i>/</i> .						24a. Was a perform	n autopsy ned?	available	topsy findings a prior to ion of cause ?		
						1 🗆 Ye	s 20 No	1 ☐ Yes	2□ No		
o medical					26. Place of Dec	th (Check only on	(				
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	investigation Could not be determined Certifying Phylidedical Exam	investigation Could not be determined  28e. Place of Injury building, etc.  Certifying Physician: To the best of sedical Examiner: On the basis of earn manner state	investigation Could not be determined  28e. Place of Injury - At home, for building, etc. (Specify)  Certifying Physician: To the best of my knowledge fedical Examiner: On the basis of examination are and manner stated.	investigation  Could not be determined  28e. Place of Injury - At home, ferm, street, fact building, etc. (Specify)  Certifying Physician: To the best of my knowledge, death occurred fedical Examiner: On the basis of examination and/or investigat and manner stated.	Investigation  Could not be determined  28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)  Certifying Physician: To the best of my knowledge, death occurred at the time fedical Examiner: On the basis of examination and/or investigation, in my cand manner stated.	Could not be determined   28e. Place of Injury - At home, ferm, street, factory, office	investigation  Could not be determined  28e. Place of Injury - At home, ferm, street, factory, office  28f. Location (St. City or Town)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the collection of the basis of examination and/or investigation, in my opinion, death occurred at the time, dand manner stated.	investigation Could not be determined  28e. Place of Injury - At home, ferm, street, factory, office  28f. Location (Street and Number of Town, Stete)   investigation Could not be determined  28e. Place of Injury - At home, ferm, street, factory, office  28f. Location (Street and Number or Rural Route City or Town, Stete)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.  Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cand manner stated.  Certifier  29c. License number  29d. Date signed (Month, Day, 1)			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Physician Yeer INA E. GROTON 12:03 MM 02 15 00 /Medicai 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HARTLE Wordster HALL NURSING HOME Ocomoke If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XF Months 86 Yrs. Director 212-10-2301 8/10/13 MARYIANN Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete show 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD 28a-f Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò or items 23s 2224 Tulls Corner Rd. Funerai 21851 USA 14. Rece - American indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2½ No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by Specify: white 3- Widowed 4 □ Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ai Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked other any injury or other traumatic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Lo John Hinman Lettie Rebel 19a. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alvin Taylor (brother-in-law) 2224 Tulls Corner Rd., Pocomoke City, MD 21851 Dele 20c. Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 

Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parksley Cemetery 2/17/00 Parksley, VA 21. Signeture of Funer Service Licensee 22. Neme end Address of Fecility m01129 Holloway Melson Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately 1.4.

App Approximete interval Between Onset end Deeth **Physician** /Medical tmmediete Cause (Finei diseese or condition resulting in deeth) Examiner Examiner ate has been signed by the attending physician and page 2 should be detached for use es the buriel-transit The lew requires that the death certificeta be axecuted Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): P.0. Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Division of Vital Records, þ Be Completed 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? After this certificate has Vementia VA ema 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes cese referred to medicel examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturei death. A Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted. Medicai 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) fregory Name and address of person who completed ceuse of death (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR; SALISBURY, MD 21801
31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture 31. Dete filed (Month, Day, Yeer) State Registrar

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State Registrar

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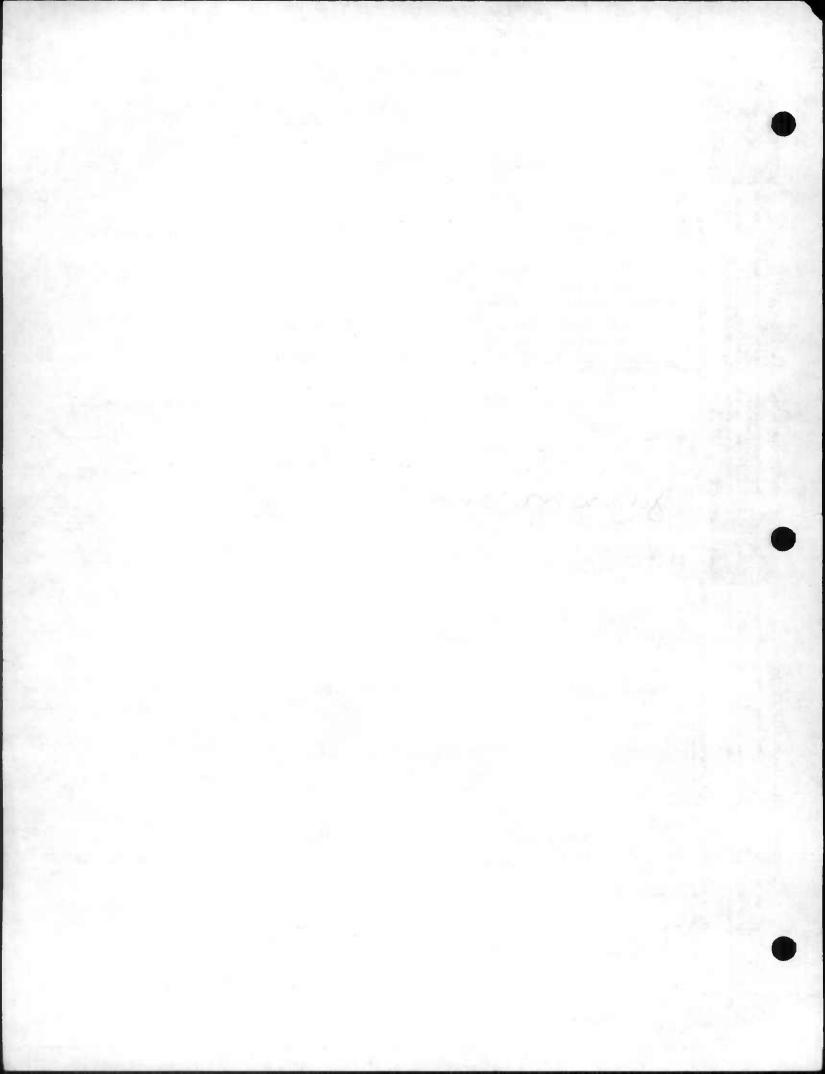
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32. Registrar's Signatura Deneva

30. Name and address of person wito completed cause of death (item 23s) (Type, Print) hutero

oaks

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death February 7, 2000 Leon Orvn Gunn Jr. 2:30 PM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death 201 Marion Quimby Drive Queen Anne's Stevensville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) XXM 2□ F 453-20-6417 78 Yrs. October 10,1921 Tennesse Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Queen Anne's Stevensville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21666 201 Marion Quimby Drive USA 12. Was Decedent Ever in U,S. Armed Forces? ▼Ø Yes 2 □ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Bieck, White, etc. 1 ☐ Never Merried 2 Married 1□ Yes ZNo Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government & College (1-4or 5+) Elementary/Secondery (0-12) Real Estate U.S. Airforce & Real Estate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Leon Oryn Gunn Vivian Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Janice Marie Gunn/ Wife 201 Marion Quimby Dr. Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville Cemetery February 11, 2000/Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam loca. 106 Shamrock Rd. Chester, Maryland 21619 23a. Pert1 Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shoot, or heer failure. List only one cause on each line. Approximete Intervai Between Onset and Death lastoma Multiforme 11/20 Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy 1 Yes 2 No 1 Yes 2 No 26. Plece of Death (Check only ope) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work?

**Physician** /Medical Examiner and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Funeral

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Completed

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ism 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effort Department of Health and Mental Hygiene.
Important: If Itsm 27 is marked other than "natural", or fran any injury or other trainment.

Maryland 21215-0020

Baltimore,

P.O. Box 68760

Division of Vital Records,

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25. Was cese referred to medicel examiner? 1 ☐ Yes

> 5 Pending investigation 1 Natural 2 Accident 3 Suicide

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(Check only one)

29a. Certifier

6 Could not be determined

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifie

29c. License number 3706

29d. Dete signed (Month, Day, Year)

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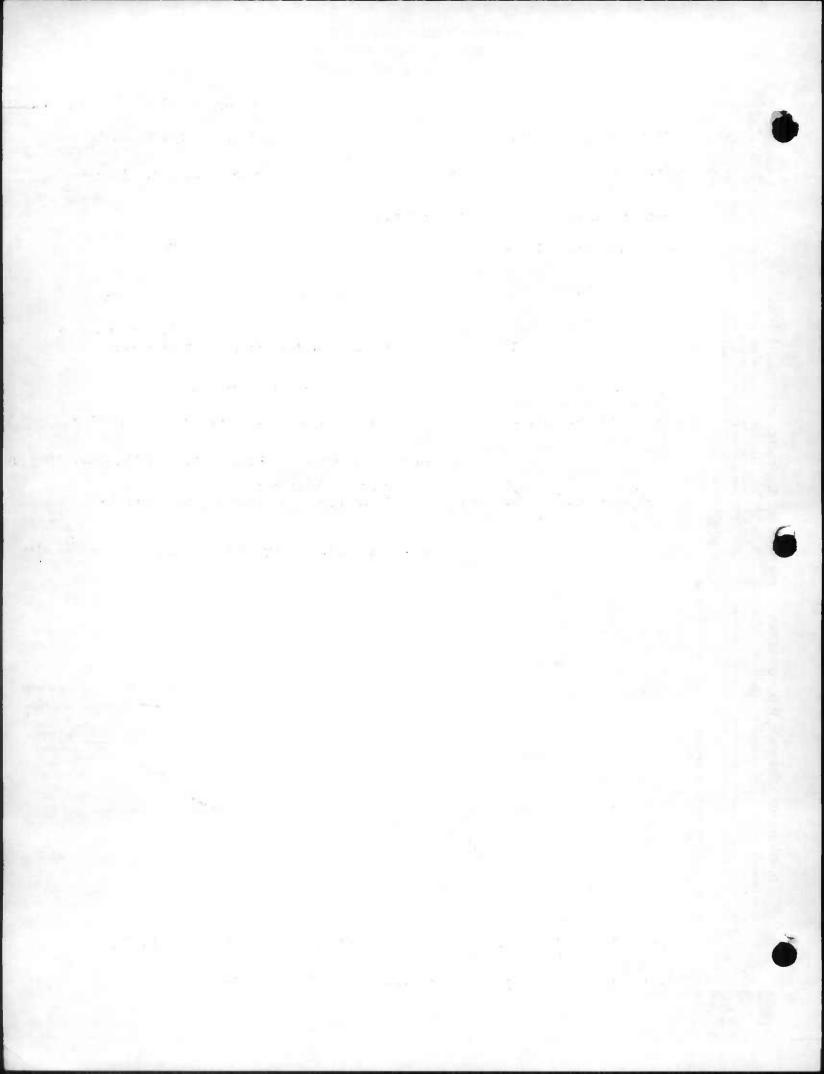
30 ame and a ress of parson who completed ceuse of deeth (Item 23a) (Type, Print) Rd Stevensulli

31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Yaar Month ANNA CATHERINE GILPIN 4b. City, Town, or Location of Death 30, 2000 7:45 A.M 4a Facility Name (If not institution, giva street and number) 4c. County of Death Memorial Hospital & Medical Center Cumberland Allegany If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Deys Months Hours 1 M ATT 212-38-6261 60 Yrs APRIL 14 1939 MARYLAND Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 12514 PETE'S DRIVE S.E. 21502 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc 1 Never Merried 2 Married 1 ☐ Yes 2 X No If Yas, Giva 1 ☐ Yas 2 ☒ No Specify: Specify: WHITE 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 U.F.C.W. LOCAL#27 OFFICE MANAGER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) ALFONSUS GRABENSTEIN LENORE HEMING 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) IRVIN EUGENE GILPIN HUSBAND 12514 PETE'S DRIVE S.E. CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete cematary, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stete CUMBERLAND CREMATORY JAN 31 2000 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Ligensee 22. Nama and Addrass of Facility MERRITT-ADAMS FUNERAL HOME P.A. essell 05. 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Entar tha disaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final Ovarian cancer disaasa or condition rasulting in death) 2 years Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaese or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 30 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 2 No Other: 4 Nursing Homa 5 Rasidenca 8 Othar (Specify) 1 Yas 1- Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Netural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida

Examiner The law requires that the death certificate be asscuted burial-tran Box 68760. Physician/Medical the USB 88 for use as been signed by the a should be detached? Records, P.O. Completed by has page 2 certificata director, Be Certification: To this

212-38-6261

Anna Gilpin

**Physician** 

/Medical

Examiner

**Funeral** 

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permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hygiene. Important if Item 27 is merked other than any injury or other traumatic event the Medical

**Physician** /Medical

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31. Data filed (Month, Pay, Year) JAN 3 1 2000 State Registrar

29a. Cartifiar (Check only one)

29b. Signatura and titla

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

Poonai, 920 National Highway, Cumberland, MD 32. Registrar's Signature

the Certifying Physician: 10 tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end/menner stated.

29c. License number

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29d. Data signed (Month, Day, Year)

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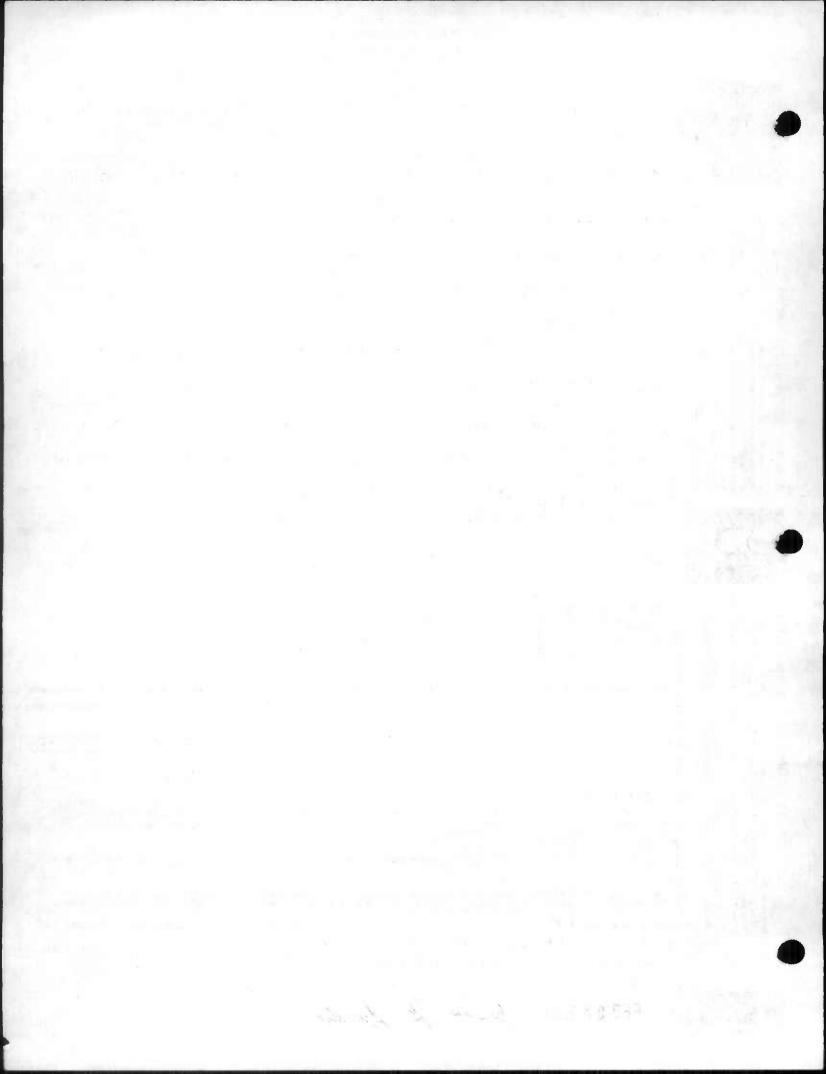
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Death **Physician** Month Yeer February 6,2000 RICHARD HUNTLEY GILMORE 6.00 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth -4c. County of Deeth Examiner LIONS MANOR NURSING HOME CUMBERLAND ALLEGANY If Under 24 Hrs. Hours | Min. If Under 1 Yeer 5 Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F 219-56-9914 48 Yes Director APRIL 17 1951 MARYLAND Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, ma Medical Examinar must be notified at 1 Yes 2 □ No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 216 SOUTH WALNUT PLACE Funeral U.S.A. 21502 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2X☐ No. If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus filed within 72 hours efter 1 ☐ Never Married 2 Married 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 BURNS SECURITY SERVICE SECURITY SERVICE Ith end Mental Hvr Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD HUNTLEY GILMORE JR. IRENE MAXINE POWELL 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health e Important: if item 27 is eny injury or other trea HILDA JEAN GILMORE WIFE 216 SOUTH WALNUT PLACE, CUMBERLAND MARYLAND 21502 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) CUMBERLAND CREMATORY FEB 8 2000 CUMBERLAND MARYLAND 21 Signature of Funeral Service Lice 22. Name end Address of Feclify MERRITT-ADAMS FUNERAL HOME P.A. emillo 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.

Approximete shock, or heart feiture. List only one ceuse on each line. d. Onset end Deeth Physiclan of /Medical Immediate Ceuse (Finel Carcinoma diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. signed by the ettending physician d be deteched for use as the buris Physician/Medical Due to (or es e consequence of): P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No Division of Vital Records, à cate has been sig pege 2 should b 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? After this certificate 1 ☐ Yes 2 🗵 No Physician: Be 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) the funeral 27. Manyler of Deeth 1 Naturel 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner as steted.

Medical Framiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certil 29c. License number 29d. Date signed (Month, Day, Year) Ry 2000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3 Kent Avenue Cumberland Guota MD 31. Dete filed (Month, Dey, Year) State 32. Registrer's Signeture FEB 0 8 2000 Registrar



## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certific	cate of Death	Re	g. No.	06250					
	Decedent's Nama (First, Middle, Last)		2. Deta of Death Month	1	3. Time of Death					
Physician /Medica	Harry . (21 lpin		January	28, 200						
Examine	As Facility Name (Mark institution of a street and auchor)	4b. City, Town, or I		4c. County of						
	Memorial Hospital	Cumberlan	d	Allega	inv					
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If t	Inder 1 Year   If Under 24 Hrs.	8. Data of Birth (Month, Day,							
Director	220-34-2179 1 X 2 F 60 Yrs. Mor	nths Days Hours Min.	May 9,	1939	). Birthplace (State or Foreig Country) MD					
anyland	10a. Stata 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yas 2 ☐ No					
M of Maria	MD Allegany Cumb	erland			Δ.					
الله الله	10e. Street and Number	f. Zip Code		g. Citizen of Wh	at Country?					
23a	413 Cedar Street	21502		USA						
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or home 23e or 28e-f show any injury or other treumatic event, in Model Emminer must be notified a	1 Nevar Married 2 Married 1 Yas 2 M	Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puert es 2 DNo Specify:	pecify Yas or No- o Rican, atc.)	Black,	Amaricen Indian, Whita, atc.					
DOOUL NOT	3 Wildowed 4 Divorced Yaar or Datas:	X			white					
5-(	15. Decedant's Education (Specify only highest grada completed)  Elemantary/Secondary (0-12)  12  Collega (1-4or 5+)  Retire  7. Father's Nama (First, Middle, Last)	Usual Occupation of work done during most of wor OT use retired)	king 1	6b. Kind of Bust	nass/Industry					
21 Page 1	Elemantary/Secondary (0-12) Collega (1-4or 5+)									
2 Page 1	12 Retire	d Employee		'ire Co						
D Effe	17. Fathar's Nama (First, Middle, Last)		na (First, Middle, M							
hould to district the marked marked	narry C. Gilpin	Maxine dress (Street and Number or Ru		liott)	late Tin Code)					
Ma and 2 s alth an 27 is r	Billie J. Gilpin 413 Ce	dar Street;			21502					
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours eft Poparment of Health and Mental Hyglene. Important: If New 27 is marked other than "natural", or my Injury or other treumetic event, tre Medical Event in the Control of the C	20a Method of Disposition  1 Burial 2 ACramation 3 Ramoval from Stata  20b. Ptace of Disposition cemetary, crematory	v or other place)			ty or Town, Stata					
Itin	4 Donation 5 Other (Specify) Scarpelli 21. Signature of Funeral Service Licensee 22. Nat	Funeral Hon	e2/01/	Cresap	town, MD					
Balt Permit. Department Importa		arpelli Fune								
_ 40144		mberland, Ma		21502						
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each tine.  Immediate Cause (Final disease or condition resulting in death)  AMETASTATIC MELANOMA  Due to (or as a consequence)				Interval Batween Onset and Death					
0 4					ŧ					
68760, ifficate be executed grhysician and as the bunal-fransit	Sequentially list conditions,  Dua to (or as a consequence	e of):								
o o o o o o o o o o o o o o o o o o o	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as a consequence of):									
68760, ficate be ex	Causa (Disaase or Injury c									
0 0										
Box 68 eath certific attending platfor use as 1	d									
P.O. Box at the death cert of by the attendin etached for use	Part It. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23b. Did tobacco use contribute to the caus							
P.O. at the d by the etache			V	Probably 4 Unkno						
			1 🗆 Ye	74.0						
Records, P.O. Box			24a. Was ar		24b. Wara autopsy findings					
O be should			perform	ned?	available prior to completion of cause of death?					
Reco law rec				V	\					
of Vital Rechystelan: The law his certificate has buildirector, page 2 s			1 Ya	s 200 No	1 □ Yas 20 No					
/ita	25. Was casa rafarred to medicel		ath (Check only one	a)						
ion of Vital nding Physician: Tath. r: After this certificat is funeral director, p	2 1 Yas 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3		loma 5 ☐ Raside							
P P P P P P P P P P P P P P P P P P P		28c. Injury at Work?	28d. Describe ho	w injury occurred						
ttendir death. ctor: At y the fu	Accident Investigation									
Division of a standing Phy after death.  Director: After this d in by the funeral	2 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, fabuilding, atc. (Specify)	actory, office	28f. Location (Str City or Town		or Rural Route Number,					
Hospita 14 hours Funeral tely fille	29a. Cartifiar  (Check only one)  29a. Cartifiar  (Check only one)  (Check only one)	erred at the tima, data and place ation, in my opinion, death occu	, and due to tha ca rred at the tima, da	use(s) and manr ita and placa, an	ner as stated. d dua to the cause(s)					
within To the comple		29c. License number	29	d. Data signed	(Month, Day, Year)					
P = 1 8 /				water original (						
6	Am daw MI)	D46346	J	anuary	3, 2000					
0.4	30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)									
NA	DI. nulla Shakii Johnson heights heurea	1 Bldg. 625 Ker	nt Avenue	Ste 30	4 Cumberland					
State	De Date died (14 The Day Mone) De Day De Assert Clause	1								

Registrar

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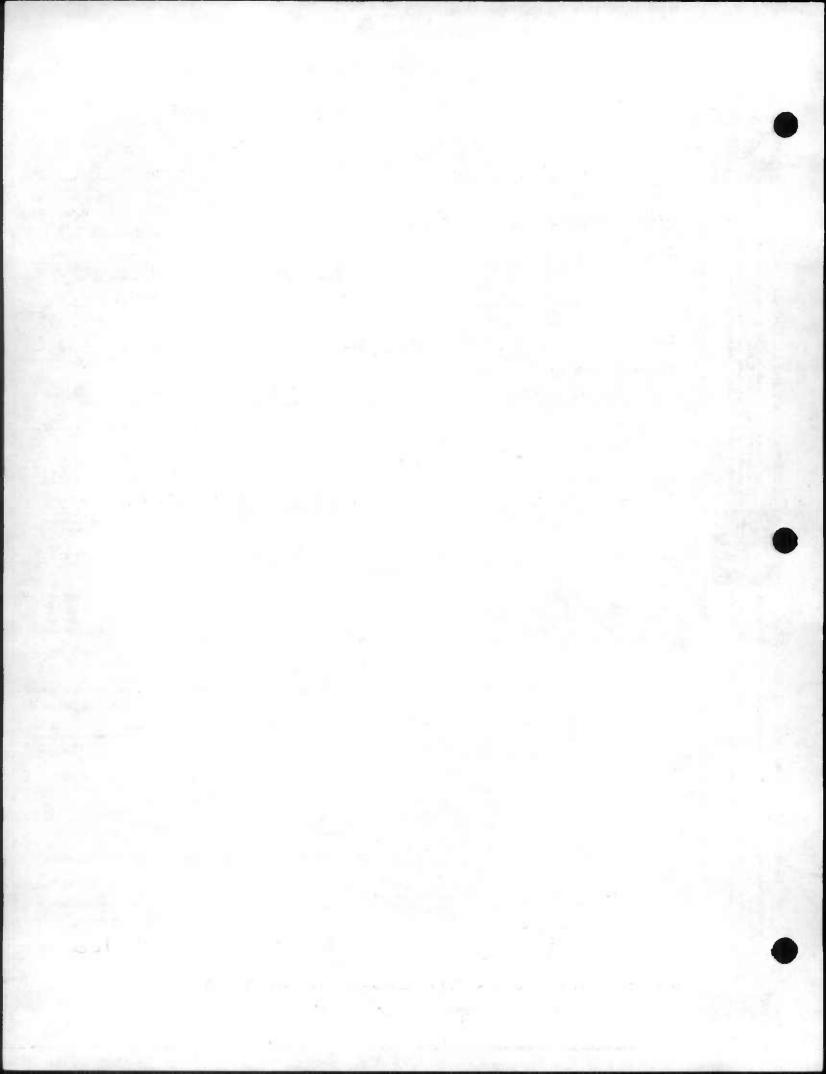
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles Fay Hough Jr. February 2000 7:50 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Freder If Under 24 Hrs. Frederick 8. Date of Birth (Month, Dey, Year) Memorial 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** Months Davs Hours 218 72 4407 Usuel Residenca of Decedent 1 M 2□ F 10 Director 1arch 12,1959 death with the Maryland 10a. Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location worde ! 1 Yes 2 No Funeral Director Frederick -rede 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8/2 21701 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
if Yes, Give
Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelih and Mentel hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercition Page. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self-employed arpenter 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tauble 2 -harle 5 Hough 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) +, Frederick mo 21701 DUSAN 20b. Place of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removal from Stete Kesthaven Mem, Gardens Frederick 4 □ Donation 5 □ Other (Specify) 2-2-00 22. Name and Address of Fecility Zumbrun Functal Home 21. Signature of Funeral Service Licansee 11. Emm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, a confit failure. List only one cause on each line. OX Rd, Eldersburg MD Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) SEPSIS -72 hus Examiner Due to (or as e consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or as a consequence of): USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA (DIFFUSE INTERSTITIAL þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? AULTIFORME GUOBUSTOMA page 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) 1 Ves 2 No Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3D DOA After this funeral 28a. Date of tnjury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation Hospital or Attandin 24 hours after death.
 Funeral Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide TS Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a, Certifier To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examend menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32171 02/01/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 328 21793 RICHARD L. GOUGH Box Po and 31. Dete filed (Month, Dev. Year) 32. Registrary Signature State

DHMH 16 Rev 6/95

Registrar

oaks



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev 26 2000 12:15pm Wade Follis Hursey 01 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Maryland Masonic Homes Baltimore Cockeysville | H Under 1 Yeer | H Under 24 Hrs. | S. Dete of Birth | Month, Day, Year | Oct. 23, 1906 9. Birthplece (State or Foreign S. Carolina 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 10 M 2□ F 93 163-03-8402 Vre Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location Cockeysville 10d. Insida City Limits Baltimore MD. 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21030 300 International Circle 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) year Shell Oil Co. Bookkeeper 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Rev. John A. Hursey Mattie Humphrey 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 300 International Cir. Cockeysville, Md. 21030 19e. informant's Neme/Reletionship (Type, Print) (self) Wade F. Hursey 20b. Piece of Disposition (Name of 20c. Location - City or Town, State Frederick, Md. 20a. Method of Disposition 1/31/00 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Mt Olivet Cemetery ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. MARKET ST. FREDERICK, MD. 21701 as the that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death Immediate Cause (Finei disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chomi OBSTutne PUZmony Disease, Denoution, Conjestine Heart Failure, Hypertersion 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Prostatic Cancar. NO 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of injury 28d. Describe how Injury occurred 28c. injury et Work?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

þ

Completed

Be

2

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examines must be not if a gonce.

Baltimore, Maryland 21215-0020

ettending physician and for use as the buriel-transit 88 signed by the e d be deteched f page 2

certificate hes After this funerai

Physician/Medical

Division of Vital Records, P.O. Box 68760,

à Completed Be

Examiner

Certification: To

1 Neturel 2 Accident

3 ☐ Suicide

29a. Certifiar

4 Homicide

(Check only one)

29b. Signeture and title of cartifier

that the death certificate be executed or Attending Physician: 24 hours after death. Funerel Director: Af filled in by Hospital

To the Hosp within 24 hor To the Fune completely fi

DHMH 16 Rav 6/95

State Registrar

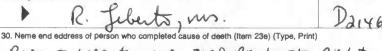
Medical

31. Dete filed (Month, Dey, Year)

RUBERT LIBERTO

5 Pending Investigation

6 Could not be determined



28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 21464

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner as steled.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated.

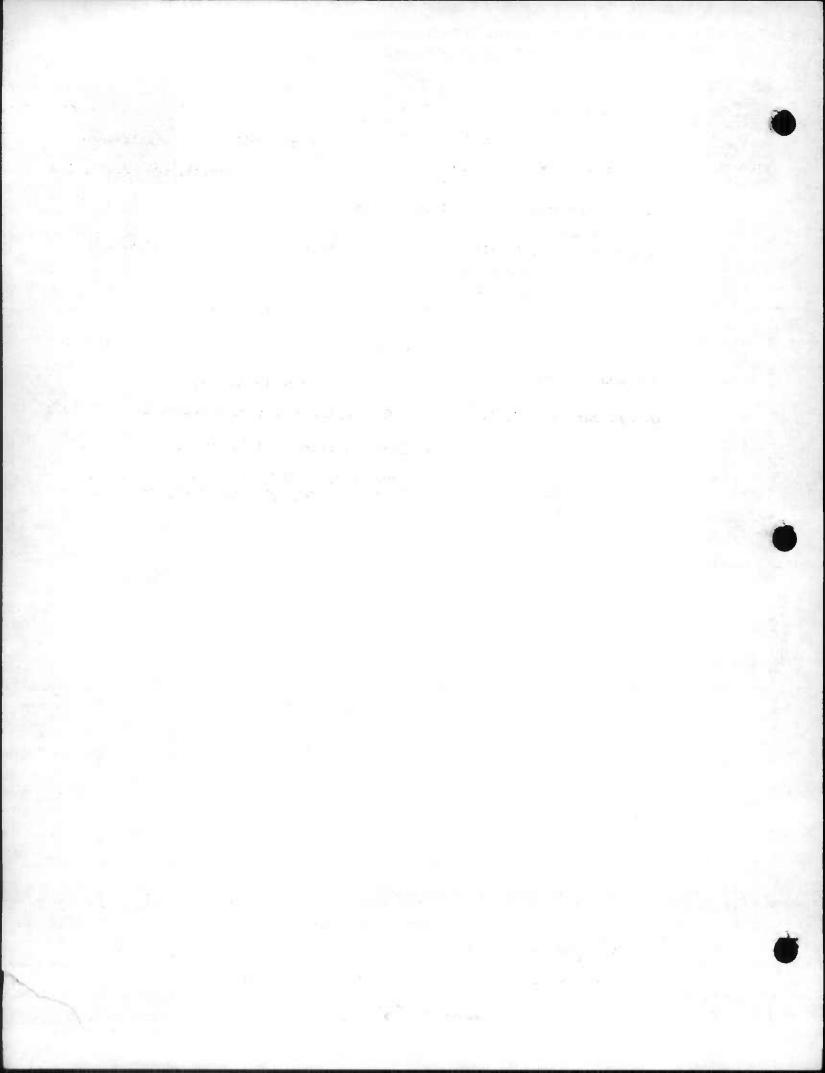
1 Yes 2 No

29d. Dete signed (Month, Day, Year) 100

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mp. 3508 BANK ST BALTO, 21214

32. Registrer's Signeture

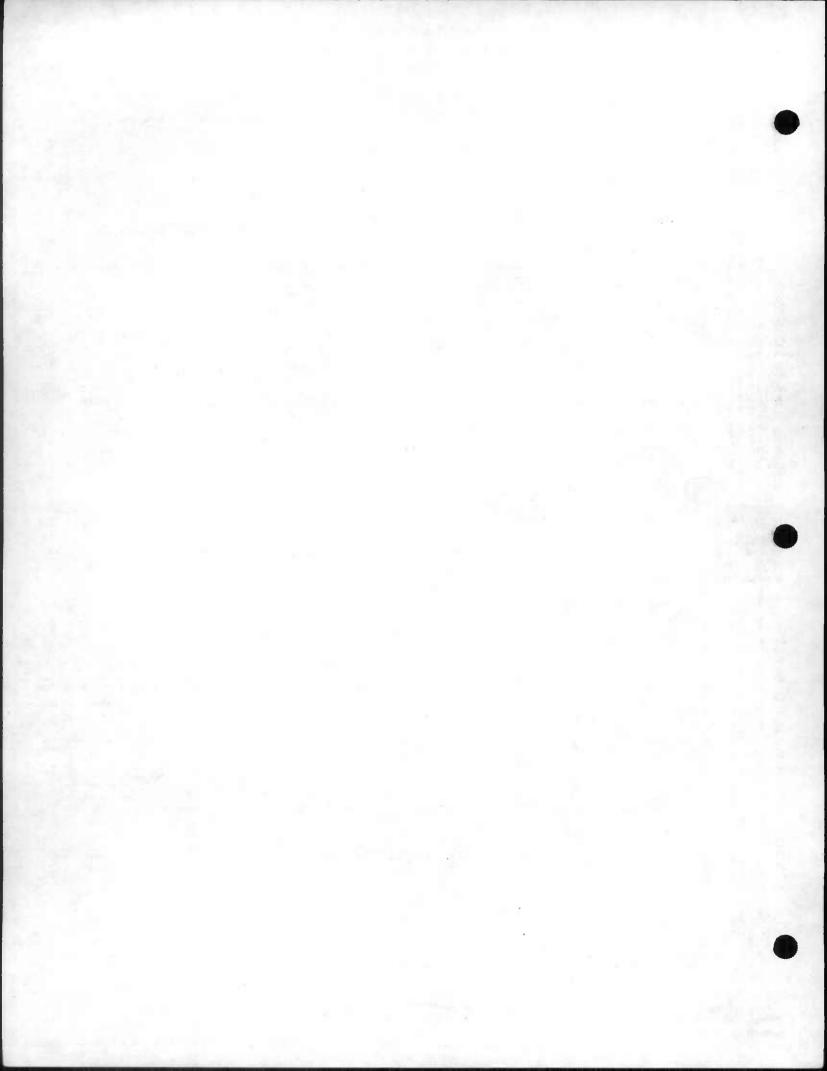


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State of Maryland / Department of Health and Mental Hygiene 00 06253

			Cei	tificate of	Death	R	eg. No.				
Physician	1. Decedent's Name (First, Middle, La		Hosen			2. Dete of Dear		Xpar	3. Time of Death		
/Medical	Katherine	Rebecca	Harp		th City Town and a	Februar			10: 45 P		
Examiner	4a Facility Name (If not institution, given Northampton Ma		are Cent	ter	4b. City, Town, or Lo		4c. County		derick		
Funeral	5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday)	If Under 1 Yee	r If Under 24 Hrs.	8 Date of Birth	Year	9. Birthpl	lece (Stete or Foreign		
Director	214-10-5612 Usual Residence of Decedent	OM 20 F 9	)∠ <sub>I</sub> Yrs.	Months Days	Hours Min.	uly 15,	1905	Caup	Tyland		
unylan ahow dat	10a. State 10b. County	10c.	City, Town or Lo					10	Od. Inside City Limits		
or 28a-f show be notified at Director		erick		Frederi	ck				1  Yes 2 No		
6 2 M IS	10e. Street and Number 200 East 16th S	treet		10f. Zip Code	1701		0g. Citizen of \	S.A.	try?		
d within 72 hours after dea glore. It has Medical Examinar in Completed by Funes	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Wes Decedent of I Yes, specify Cu I ☐ Yes 2 No	Hispanic Origin? (Speban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blee	ck, White, o	etc.		
72 m matter digal	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	ient's Usuel Occu	upation e during most of worki ed)	ing	16b. Kind of B	usiness/Ind	lustry		
ed within 72 ho ygiene. er than 'natur f, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)	Switch	Board C	perator		Power	Compa	any		
hents! Hyg hents! Hyg head other fic event, O Be C	17. Father's Name (First, Middle, Last, James E. Kinna				18. Mother's Neme Minnie G	(First, Middle, I Sulcer	Maiden Sumen	ne)			
and 2 shows alth and 3, 27 is many ar traumment.	19a. Informant's Name/Relationship (Type, Print) Hubert A. Harp, Jr./Son  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, 915 Cherokee Trail, Frederick, Maryland										
mit. Pages 1 i partment of He portant: If lises y injury or othe	20a. Method of Disposition  1	Removel from State	D. Place of Dispo cemetery, crem Mt. Oliv	netony or other of	ery Feb.		20c. Location -				
Departit Departit Importa any inji	21. Significant of Funeral Service Licer	L 11 n		. Name and Add Keeney &	D 5 1 1	Funeral	Home		. 01701		
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications hat caused the d	eath. Do not ent	106 East er the mode of dy	Church String, such es cardiac d	treet, For respiretory err	rederio	ck, M	Approximate		
Physician	shock, or heart failure. List only	one cause on each line.						1	Interval Between Onset and Deeth		
/Medical Examiner	Immediate Cause (Finel disease or condition	a A CUT	E URIA	JARY T	PACT INF	BETLON			~72 hrs		
	resulting in death)										
n and isl-transit		b			<u> </u>			1			
ifficete be executed to physicien and as the burtal-transit Aedical Examin											
ficete be ex physicien is the burla edical E	Cause (Disease or injury that initiated events resulting in death) Last										
2 2 2	lesoning in detail) Last	d									
et the death certi d by the attending stached for use a Physician/M	Deat II Other significant and dislance		and the state of t	4.4.4	to a fee Dead	Dide-		1	the same of death?		
by the arche	Part II. Other significant conditions of	230. Did to	i tobacco use contribute to the cause of death Yea 2 No 3 □ Probably 4 □ Unknow								
	Demove		- 10 100 2 PNO 30 F1000								
requir Nens should	PERLPHO	PERIPHONE UNSCULE DISONSE							ere eutopsy findings eilable prior to mpletion of cause death?		
sician: The lew centificate has t lirector, page 2 a	V DUDUS	STASIS DENA	ATIONS			1 Y	es 20 No	10	Yes 2□ No		
Physician: Tithis certificate ral director, pr.: To Be Co.:	25. Was case referred to medicat	3 06313 0210-0	RUTUS		26. Place of Deet!	h (Check only on	ie)				
Physician: this certific ral director.	examiner? 1 Yes 2 No	Hospitet: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA	ther: 4 Nursing Ho	me 5 Reside	enca 8 🗆 Ott	ner (Specif)	y)		
Attending Pi or death. ector: After it by the funeral	27. Manner of Death  DENatural 5 Pending  2 Accident investigation		28b. Time of Injury	W	ury et ork? ] Yes 2 No	28d. Describe ho	28d. Describe how injury occurred				
tal or Attanding P is elected to the funer led in by the funer Certification:	3 Suicide 6 Could not b	28e. Place of Injury - A building, etc. (Spe	281. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or Attanding Physical Within 24 hours efter death.  To the Funeral Director, After this completely filled in by the funeral director.  Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my liner: On the basis of exam and manner stated.	mowledge, death ination and/or inv	occurred at the restigation, in my	time, date end place, opinion, death occurr	and due to the cred et the time, d	ause(s) end ma ate end placa,	enner as st and due to	ated. the cause(s)		
To the comp	29b. Signature and title of partition	2		53.0	nse number 2171		<sup>9d. Date signe</sup> Februar				
	30. Name and address of person who Richard L. Gough	completed cause of death (I	tem 23a) (Type,	Print) k Street	, Walkersv	rille, M	aryland	1 2179	93		
State				- /	4	,	-		•		
Registrar	31. Date filed (Month, Day, Year) FEB 0	7 2000	wa.	Ø. /	park						

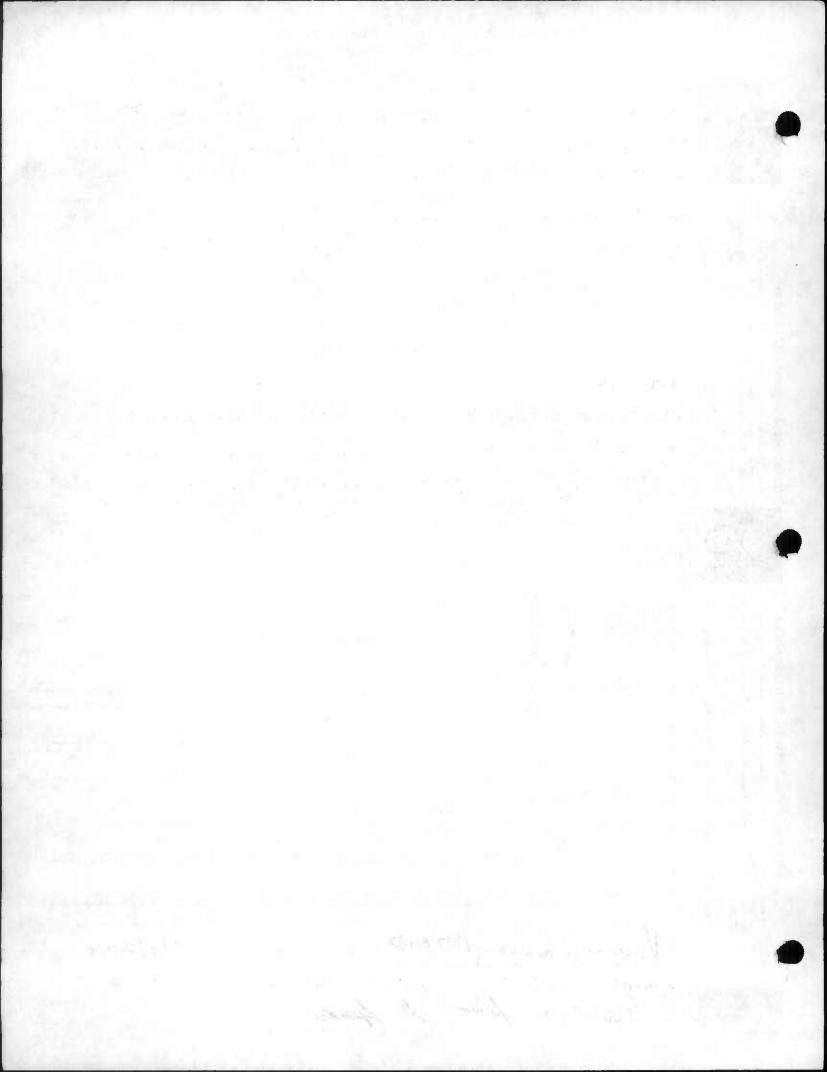
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					Cen	tificate of	Death		Reg. No.	00204	
Phys	sician	1. Decedent's Name (First, Middle, L	ast)					2. Date of D		3. Time of Death	
	dical	PRANCES	Hersh	berg	eR			Feb	3,	2000 7 pm	
Exar	niner	4a. Facility Name (If not institution, g	^ <u>-</u>	,			4b. City, Town,	or Location of Dea		y of Death	
		5. Social Security Number 6.	CENIER Sex 7. AG	-	inth day.	If Under 1 Year	SAL1	SDURS	1 Wic	comico	
Funer Direct	_	214–42–5809 Usual Residence of Decedent	1□ M 2 F	e (In yrs. last b	Yrs.	Months Days		Hrs. 8. Dete of 8 (Month, D	1912	9. Birthplece (State or Foreig Country) Philippines	
how		10a. Stete 10b. County		10c. City, Tov	wn or Loc	ation				10d. Inside City Limit	
e Ma	cto	Maryland Wicom	ico	Salis	sbury	Į.				1 □ Yas 2 1 N	
23a or 2	Funeral Director	10e. Street end Number 1216 Taney Ave.			10f. Zip Code 21801				10g. Citizen of USA	What Country?	
be filed within 72 hours efter death with the Maryland Hygiene.  did other than "natural", or items 23a or 28a-f show event, the Medical Evans or must be notified at	by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	Ever in U,S. No		as Decedent of Yas, specify Cub		(Specify Yas or Nuarto Rican, atc.)	No- 14. Race - American Indian, Bleck, White, atc.  Specify: White		
72 ho natur	D D	15. Decedent's I	Education	168	a. Decede	nt's Usual Occu	pation	and the second	16b. Kind of E	of Business/Industry	
within ene. than	Completed	(Specify onfy highest g	College (1-4or 5	+)	16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)  Secretary		during most or	working	4		
should be filed nd Mentel Hygis marked other umatic event, II	To Be C	17. Fethar's Name (First, Middle, Las Harry Farmer	t)					ame (First, Middle, Maiden Sumema) Ve Osborn			
d S		19e. Informant's Name/Relationship Merl F. Hershbe:		nd 191	19b. Meiling Address (Street end Number or Ru 1216 Taney Ave., Sa.		Rural Route Numb	per, City or Town	Stete, Zip Code)		
00-		20e. Method of Disposition  1			ition (Neme of etory or other ple Cremat		Date 2/4/00		- City or Town, State		
ing party		21. Signature of Eurogal Service Lice		* NAME OF THE PARTY OF THE PART			-	1		_	
Dep Imp	900	1 1 10 9/	10	MOIOS	Ho	olloway	Funeral	Home Pro	ofession	al Association	
		23a. Part1. Entar the disaasa, or cor shock, or heart failure. List only	nplications that caused		not enter	the mode of dvi	HILL Rd	., Salish	oury, MI	Approximata	
Physicia /Medica Examine	al er	trnmediate Ceuse (Final diseasa or condition resulting in death)	a. Cerel	rol no		ence of):	acci	dent		5 month	
en end unel-tran	Examiner	Sequentially list conditions, if env, leading to immediate cause. Enter Underlying Cause (Disease or Injury their initieted events resulting in death) Last				· ·					
eeth certificete be executed attending physicien end for use as the bunel-transit	Medical	that initiated events resulting in death) Last	c.								
e deeth ce the attend hed for us	sician	Part II. Other significant conditions	contributing to death bu	t not resulting I	in the und	lertying cause gi	ven in Pert I.	23b. Dld	23b. Did tobacco use contribute to the cause of d		
gned by	by Ph	Congestive HEART FAILURE							1 Yes 2 No 3 Probably		
e law requires that the deeth co has been signed by the attend je 2 should be deteched for us	Completed by Physician/								an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
E se	00							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Physician: The r this certificate and director, peg	Be	25. Was case referred to medical examiner?					26. Plece of D	Deeth (Check only	ona)		
this ce	0	1 ☐ Yes 2 No	Hospital: 1 Inpatier	t 2 ER/O	utpetlant	3□ DOA Ott	ner: 4 Nursing	g Home 5 Resi	dance 6 Oth	nar (Specify)	
of Attending Politics death.  Director: After the lin by the funera	Certification:	27. Menner of Death  1 X Naturel 5 Pending  2 Accident investigation			Time of Injury	M 28c. Inju Wo	y et rk? Yes 2 □ No	28d. Describe	how Injury occur	rred	
s ofter death I Director: A	Sertific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)							Street end Numl wn, Stete)	ber or Rural Route Number,	
To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral	edical	29a. Certifier (Check only one)  Certifying Pl	nysician: To the best of miner: On the basis of and manner stat	examination an	e, deeth o	occurred et the til stigation, in my c	ne, dete and pla pinion, death oc	ice, end due to the corred et the time,	cause(s) and madete end place,	anner es stated. and due to the cause(s)	
within To th	Σ	29b. Signature end title of certifier	^			29c. Licens	e number		29d. Date signe	d (Month, Dey, Year)	
		30. Name and address of person who	Dulay	MT C	m)	D3	3905		2/4	2000 2-2018	
8		VIAGINIA DULAN 31. Dete filed (Month, Day, Year)	y M.D. P.  32. Registral	O. Box	(Type, Pr	18 SA	Lisbur	sy, md.	2180	2-2018	
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		3 Des 20 V				1	ATT.				

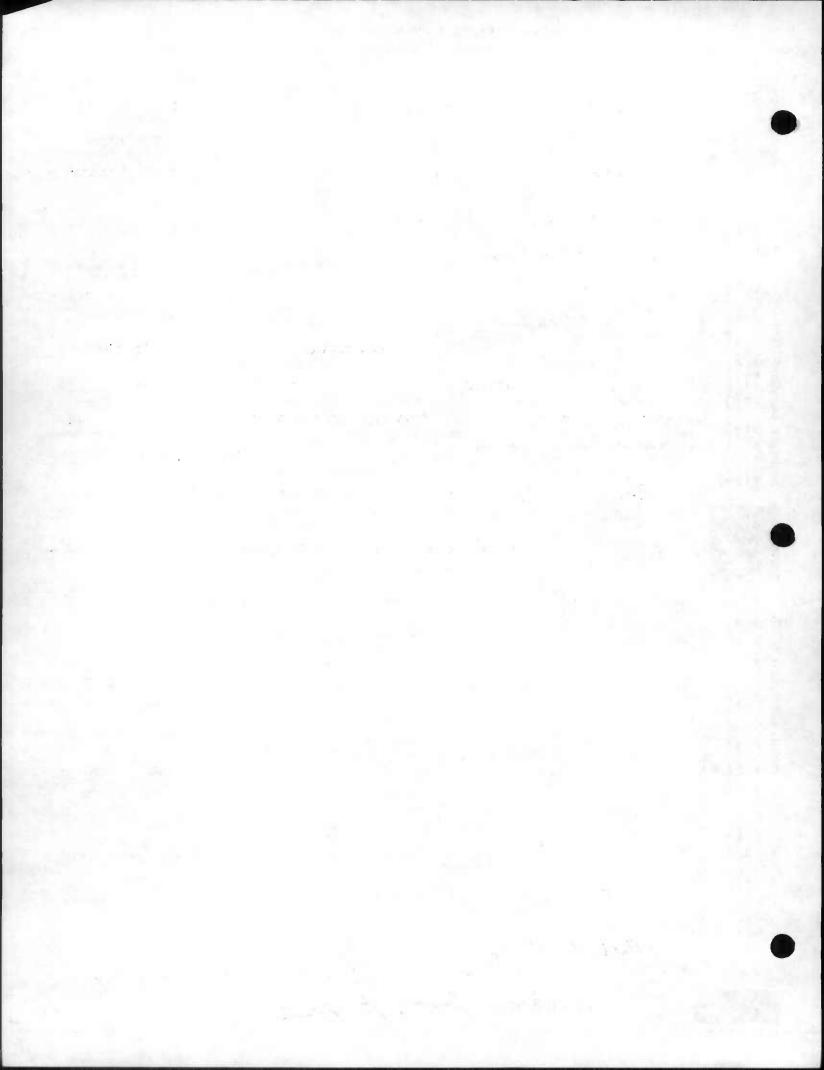
DHMH 16 Rev 6/95



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			State of Mi	arylaric				Death	nemai m	Reg. No.	0	6255		
Discontin		1. Decedent's Name (First, Middle, Li	nst)						2. Date of Do	eath Day Year		3. Time of Death		
Physic /Medi		VICTORIA	J.			HALL			FEB.		000	0800		
Exami		4a Facility Name (If not institution, gi	ve street and number)					4b. City, Town, or L						
		8025 OLD OCEAN	CITY ROAD				WHALEY	ITLLE	WORG	CESTI	ER			
Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. le	st birthday)		r 1 Year	If Under 24 Hrs.	8. Date of Bi (Month, D			klace (State or Foreign		
Director		212-44-9109	1□M 2ØF	54	Yrs.	MORRIS	Days	Hours Min.	AUG. 1			LAND		
rland		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	cation					1	Od. Inside City Limits		
a Man	ctor	MARYLAND WORCE	HALEYV	ILLE						1 ☐ Yes 2X No				
or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What										ntry?		
23a	ral	8025 OLD OCEAN	CITY ROAD				2187			USA				
eb u	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		6. 13. W	Vas Dece Yes, spe	dent of h	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	14. Race Black	- Americ , White,	en Indian, etc.		
within 72 hours after death with the Menyland with in 72 hours after death with the Menyland one. then "retural; or items 23s or 28s-f show he Wedgel Examine must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1	No	1	☐ Yes	2 <b>X</b> ) No	Specify:		Specity:	WH	IITE		
Z I Z I D-UUZU d within 72 hours af glena. r than "natural", or the Medical Enem		15. Decedent's E	ducation		16a. Deced	ent's Usu	al Occup	pation		16b. Kind of Bus	iness/Inc	dustry		
2 in 2	piet	(Specify only highest gr Elementary/Secondary (0-12)	5.)	(Give I	kind of w	ork done ise retire	during most of work d)	ing						
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should be filed and Mental Hygi marked other umatic event, I	To	JAMES	JARMO	N				BEATRI	CE	HAI	LL			
D		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street	and Number or Rui	al Route Numb	er, City or Town, S	State, Zip	Code)		
C = 01 L		LARRY P. HALL/HU	SBAND		8025	OLD	OCEA	N CITY RO	AD, WHA	LEYVILLE	, MD	21872		
of Haalt		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Na	me of		Date	20c. Location - C				
0 0 - 7		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont			LE CEM	-11.0			/10/00	WHAT.EYVT	LLE.	MARYLAND		
	8. /	21. Signature of Funeral Service Lice		DA				ess of Facility	., 10,00	WILLIELVI	وبديد	IMMILIAND		
Demit. Departimont any inj		> Charles 14	24nex	_	на:	STIN	GS F	UNERAL HO	ME, SEI	BYVILLE.	DE	19975		
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Physician		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each list.  Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death												
/Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any leading to immediate cause. Enter Indervision.										18 mg		
Examiner														
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icate be axecuted physician and s tha burial-transit	me													
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licate be av physician s tha buria	edical	Cause (Disease or injury that initiated events Due to (or as a consequence of):												
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a law requires that the de has been signed by the iga 2 should be detached	P								24a. Wa	s an autopsy ormed?		ere autopsy findings ailable prior to		
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tranding Physical Control of the funeral distribution of t	-	27. Manner of Death	28a. Date of Inju	iry	28b. Time of		28c. Inju Wo		-	how injury occurre		"		
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2 2 9 5	flea	3 Suicide 6 Could not t		ury - At hor	ne, farm, stre	et, factor	y, office			(Street and Number	er or Rura	al Route Number,		
DIVISION OF INTERPRETATION OF Attending Physics after death.  I Director: After this din by the funeral di	Certification:	4 Homicide	building, ef	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town, State)				
pepita hours ineral y filler	Salc	29a. Certifier 12 Certifying Pl	nysician: To the best	of my know	rledge, death	occurred	at the ti	me, date and place.	and due to the	cause(s) and mar	nner as s	tated.		
To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by	ledical	one)	miner: On the basis of and manner sta	r examinati ated.	on and/or inv				red at the time					
To	2	29b. Signature and title of certifier				29		se number		29d. Date signed	(Month,	Day, Year)		
		Paul K-	Herry				02	487	2	2/8/	00			
		30. Name and address of person who	completed carise of d	leath (Item	23a) (Type, F	Print)		-						
		PAUL Fleu	Ry &	560	RIU	cr.	1110	VIL.	ALL	sbury	ny	9		
Sta	ite	31. Dete filed (Month, Dey, Year) FEB (	8 2000 Registr	er's Signat	ure	4		1						
Registr	ar	FED (	2000	1	100	10.	dig	oacks!						

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** MARY HUTTON BEST February 1, 2000 1:04 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5744 Argyle Drive Parsonsburg If Under 1 Year 5. Social Security Number If Under 24 Hrs. B Date of Birth Month, Day, Year) Birthpieca (Steta or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2□ F Yrs. February 27, 1912 Minnesota Director 056-38-2142 Usuei Rasidence of Decedent 10a. Stete 10c. City, Town or Location r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 10d. inside City Limits 1 ☐ Yes 2 No Director Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5744 Argyle Drive 21849 pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ferms 29a any Injury or other traumatic event, the Medical USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? Rece - American Indien, Bleck, White, etc. 11. Meritai Status 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detas: 1 ☐ Nevar Merried 2 ☐ Merried 3altimore. Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) 12 Domestic Homemaker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Nema (First, Middle, Last) 8 Elmer Samuel Mary Helena Luke 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary R. Godfrey/Daughter 5744 Argyle Dr., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, State 1 ☐ Buriai 2XI Cremetion 3 ☐ Removal from State Salisbury Crematory 2/2/00 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Nama and Address of Facility MO1051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 DOMODON 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one causa on each line. Approximete Intarvel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition rasulting in deeth) Examiner or Attending Physician: The law requires that the death certificate be executed for use as the bunal-transit Sequentially fist conditions, if any, faading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac 01 Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes casa referred to medical exeminer? funeral director. Be 26. Placa of Death (Check only one) Other: 4□ Nursing Home 5 ☐ Residence 6 □ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Deta of fnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending invastigation e Hospital or Attending 24 hours after death. • Funeral Director: Aft 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of fnjury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide 29a. Cartifiar Medical 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha time, date end place, end dua to tha ceusa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at tha tima, data and placa, and dua to the cause(s) within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

6

29b. Signeture and title of contribution

Dellam

FEB 0 3 2000

31. Dete filed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (ftem 23a) (Type, Print)

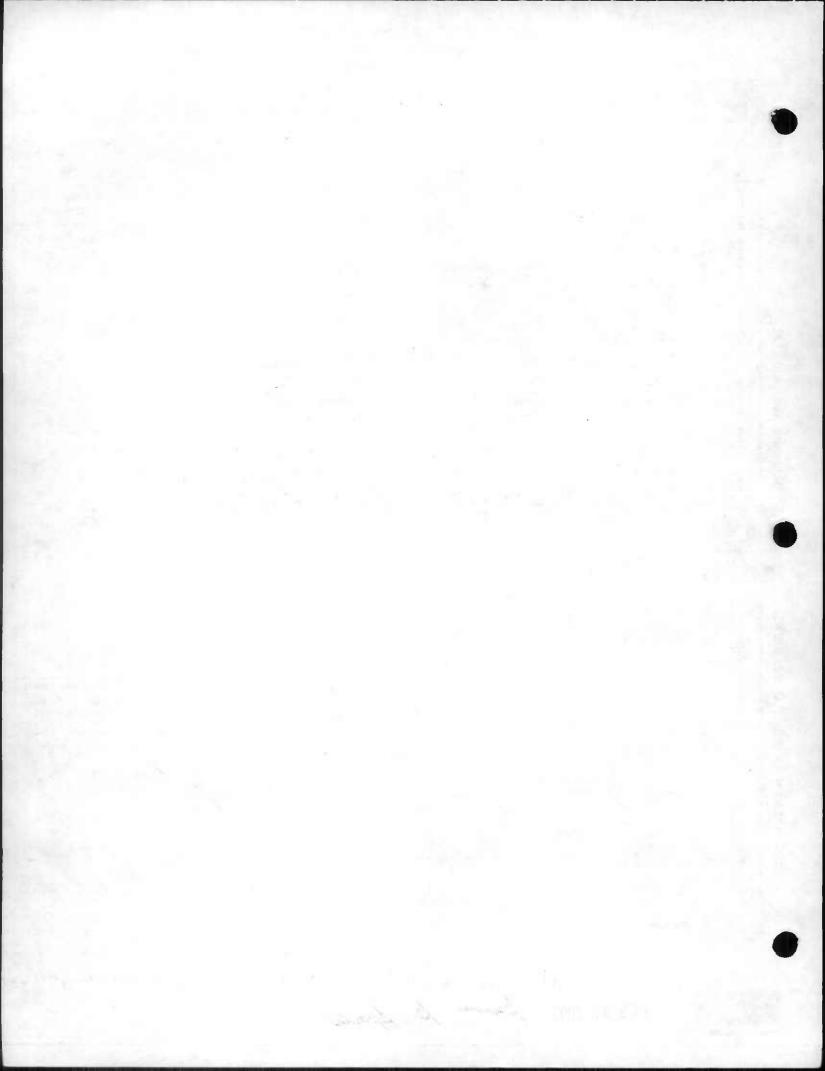
lobins 32 Registrar's Signature

DHMH 16 Ray 6/95

**ORIGINAL** 

1104 Healthway

Dr Salisbury Mdarby



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Veer LAURA FRANCES HULL Jan. 30, 2000 9:AM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Center; Genesis ElderCare Salisbury, Md. Micomico If I Inder 1 Yeer 8. Dete of Birth (Month, Dey, May 28 If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplaca (State or Foreign Months Devs 1 M 2 F Hours Maryland Yrs. 1911 88 194-20-6052 Usuel Residenca of Decedent 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Mardela 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 25313 Ocean Gateway 21837 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic None 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Maria Dashiell George Gattis 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 705 Richmond Ave. Salisbury, Md. 21801 George Church (Son) 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State Springhill Mem.Garden 4 ☐ Donetion 5 ☐ Other (Specify) Hebron, Md. 22. Name end Address of Facility Stewart Funeral Home 21. Signeture of Funerel Service Licenses B. Stewart West Rd. Salisbury, Md. 21801 821 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. **Approximata** Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Neumons Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequença of). Due to (or es e consequenca of): Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piace of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ma 23a or 28a-f shor

Nema 2

than "naturel", or Nen

Hygiene.

. Pages 1 and 2 should be filed w tment of Health and Mantal Hygier tant: If Item 27 is marked other th lury or other treumatic event, the

permit. Page Department of Important: If eny Injury or

Directo

Funeral

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Completed

the Marylend

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Physician/Medical Examiner þ Completed Certification: To Be

use as the burial-transit The law requires that the deeth certificate be executed signed by page 2 certificate has Physician: After this uneral or Attending death. after death Director: the

within 24 hours a To the Funeral C 2+n

To the Hospital

Registrar

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ATKINS 31. Dete filed (Month, Dey, Year) State FEB 01

27. Menner of Deeth

1 Netural

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

29b. Signeture end title of

2000

5 Pending investigation

6 Could not be

29c. License number

1 Destrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s)

Injury at Work?

1 Yes 2 No

DR., SALISBURY, MD.

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

21804

28d. Describe how injury occurred

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

28a. Dete of Injury (Month, Dey Year)

end menner steted.

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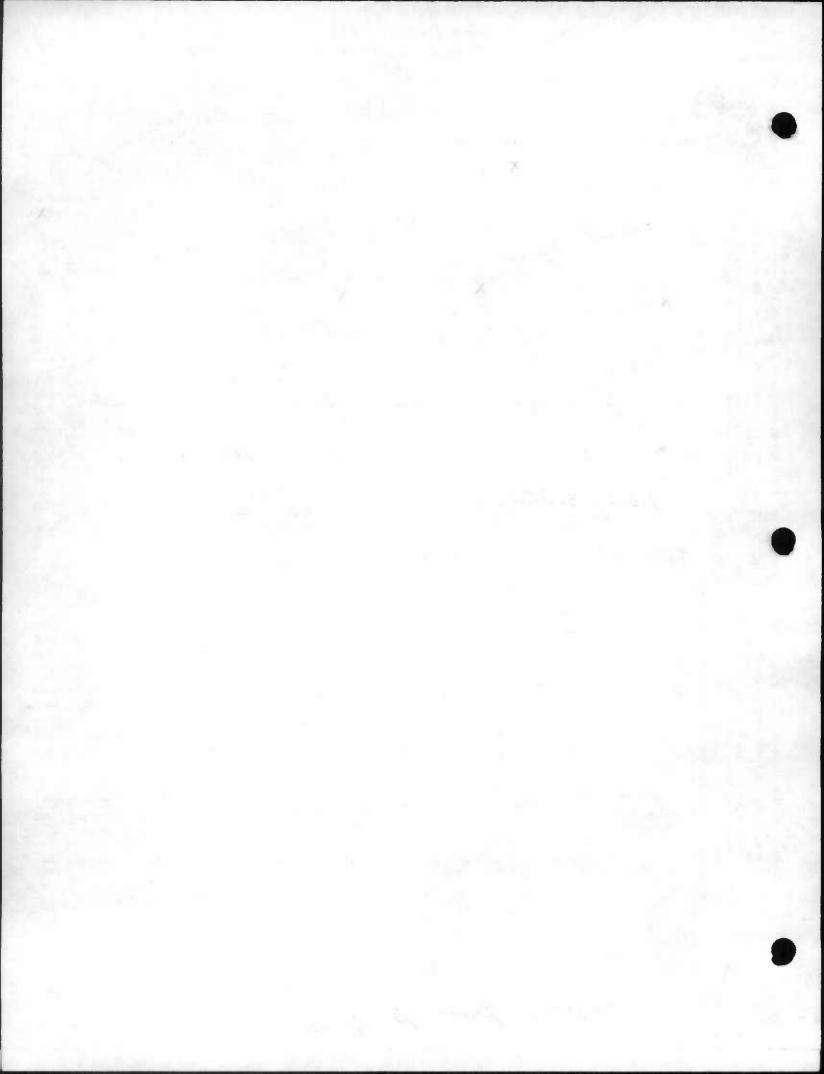
Tenera

1104 HEALTHWAY

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FRANCIS STOKES HEARN 1510 30 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY House Months Days Hours Min E C 31, 1920 5. Social Security Number 213-18-4439 7. Age (In yrs. last birthday) 79 Yrs. 9. Birthplace (State or Foreign **Funeral** 10XM 20 F DELAWARE Director Usual Residence of Decedent ahow. 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or heme 23a or 28a-f ahor the Wedical Examinar must be notified at DELAWARE SUSSEX BRIDGEVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT 1 BOX 419 19933 AMERICA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes ZY No If Yes, Give Year or Detes: 1 ☐ Never Married 2 💢 Merried Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. POULTRY Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 8YRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) parmi. Pages 1 and 2 should be file Department of Health and Mentel by Important: If Itam 27 le marked oth any Inlury or other traumatic event page. 8 WALTER HEARN IVA BOYCE 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HELEN H. HEARN RT 1 BOX 419 BRIDGEVILLE, DELAWARE 19933 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stata ODD FELLOWS CEMETERY 2/2/00 SEAFORD, DELAWARE 1 Durial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fung. 22. Name and Address of Fecility WATSON-YATES FUNERAL HOME, IN SEAFORD, DELAWARE 19973 th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 20c Part1, Egi Physician AND VALVULAR HEART DISEASE Immediate Cause ( disease or conding resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 5 Pending investigation 1 Natural
2 Accident 1 Yes 2 No To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the f death 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one)

filed within 72 hours after

Baltimore, Maryland 21215-0020

Records,

Vital

to

Division

State Registrar

29b. Signature and title of certifier

a tiled (Month, Day, Year)

JAN 3 1 2000

**DHMH 16 Rev 6/95** 

PINEBluff

Salisbury MD.

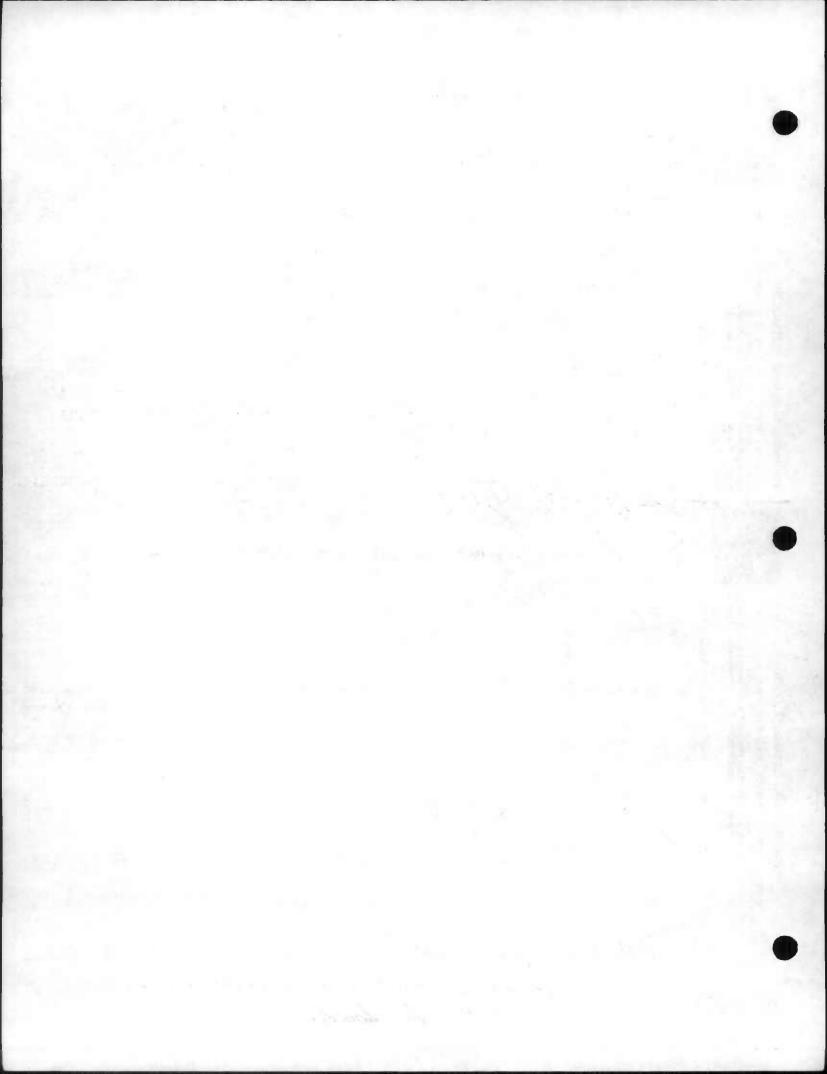
mo led cause of death (Item 23a) (Type, Print)

20

32. Pagistrar'a Signature

Seresa

MURIN



Director

Funeral

Be Completed by

2

**Physician** 

/Medical

Examiner

**Funeral** Director

Pleas	e Type or Print In						ile.
	State of Marylar				Mental Hygie	ene	0 00000
A De Land Home / Stort Middle	2	Сепі	ificate o	f Deatn		g. No.	U U5259
Decedent's Neme (First, Middle, I  CLITTE EX					2. Deta of Death Month	Day	Year 3. Time of Death
SHIRLEY 4s Facility Name (If not institution, g	M.	THE	IALL	4b. City, Town, or Lo	January Location of Death	13	
	give street end number) (EGIONAL MEDICA)	CENTER		4b. City, Town, or Lo			of Deeth COMICO
		s. last birthday)	If Under 1 Yea	ear If Under 24 Hrs.	8. Dete of Birth		
214-28-8240 Usual Residence of Decedent	1□ M 2QF 68		Months Day		(Month, Day, Y April 28		Birthplace (State or Foreign Country)     Maryland
10a. Steta 10b. County		city, Town or Local					10d. Inside City Limits
Maryland Wicon	mico	Salisbu	ry				1 ☐ Yes 2 ☑ No
10e. Street and Number		OLN-	10f. Zip Code	à	10ç	g. Citizen of Wh	nat Country?
7504 Titleist				1801		USA	
11. Meritel Stetus	12. Wes Decedent Ever in L Armed Forces?	J,S. 13. We	es Decedent of Yes, specify C	of Hispanic Origin? (Spo Suban, Mexican, Puerto	pecify Yas or No- o Rican, etc.)		- American Indian, c, White, etc.
1 Never Merried 2 Married 3 Widowed 4 XDivorced	1 Yes 2 No If Yes, Give Yeer or Detes:	10	□ Yes 2 N	No Specify:		Specify:	White
15. Decedent's (Specify only highest g	Education grade completed)	(Give kin	int's Usual Occ	ne during most of work	king 16	6b. Kind of Busi	iness/industry
Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO	O NOT use reti	red)			
12 17. Father's Neme (First, Middle, La.		Secre	etary	19 Mother's Nerr	ne (First, Middle, Ma		acturing
John T. Ruark	State of			Marie	P. Mowbr	ay	
19e. Informent's Neme/Reletionship Donald Lee Creic	ghton/Son	749	93 tit]	eet and Number or Run leist Dr.,			
20e. Method of Disposition  1 XI Burial 2 Cremetion 3 4 Donetion 5 Other (Spec	☐Removel from State cify) St	Plece of Dispositi cemetery, cremet pringhill M	Memory G	Gardens	Dete 20 1/29/00	Oc. Location - C Hebron	City or Town, State
21. Signeture of Funeral Service Lice    Xe-4   R.    23a. Part1. Enter the disease, or co	burey	Ho 50	olloway Ol Snov	w Hill Rd.	, Salisbu	ry, MD	Approximete
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	liple	Mye	Some	UI YOUR	,	Interval Between Onset and Deeth
	b.	or as a conseque	ince of): 🗸	17.11			1
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	с	(or as a conseque					
that initiated events resulting in death) Lest	Due to (c	or es e consequer	nce of):				
Pert ti. Other significant conditions	contributing to death but not re-	sulting In the unde	erlying ceuse	given in Pert I.	23b. Did tobs		tribute to the cause of death?
					24a. Wes an a performe	autopsy ad?	24b. Were autopsy findings available prior to completion of causa of death?
					1 ☐ Yes		1 Yes 2 No
25. Was case referred to medicel examiner?	Hospitel:			Other	oth (Check only one)		
1 ☐ Yes 20 No 27. Manner of Death	1029-Inpatient 2L	☐ ER/Outpatient	3LI DOA	4 LI Nursing Ho	lome 5 ☐ Residence		
27. Manner of Death  1 Statural 5 Pending 2 Accident investigati	the -	28b. Time of Injury		1 ☐ Yes 2 ☐ No	28d. Describe how		
3 Suicide 6 Could not determine	ad 286. Place of injury - At I	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  28f. Location (Street and Number or Inc.)  City or Town, State)					

Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examiner must be notified at oncies. Physician /Medical Examiner To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 0

Medical Certification: To Be Completed by Physician/Medical Examiner

30. Name and s

State Registrar

(th)

Joseph A.
31. Date filed (Month, Dey, Year) JAN 2 8 2000

son who completed ceuse of death (Item 23a) (Type, Print) RASSO 32. Registrer's Signeture

20507

29d. Date signed (Month, Day, Year)

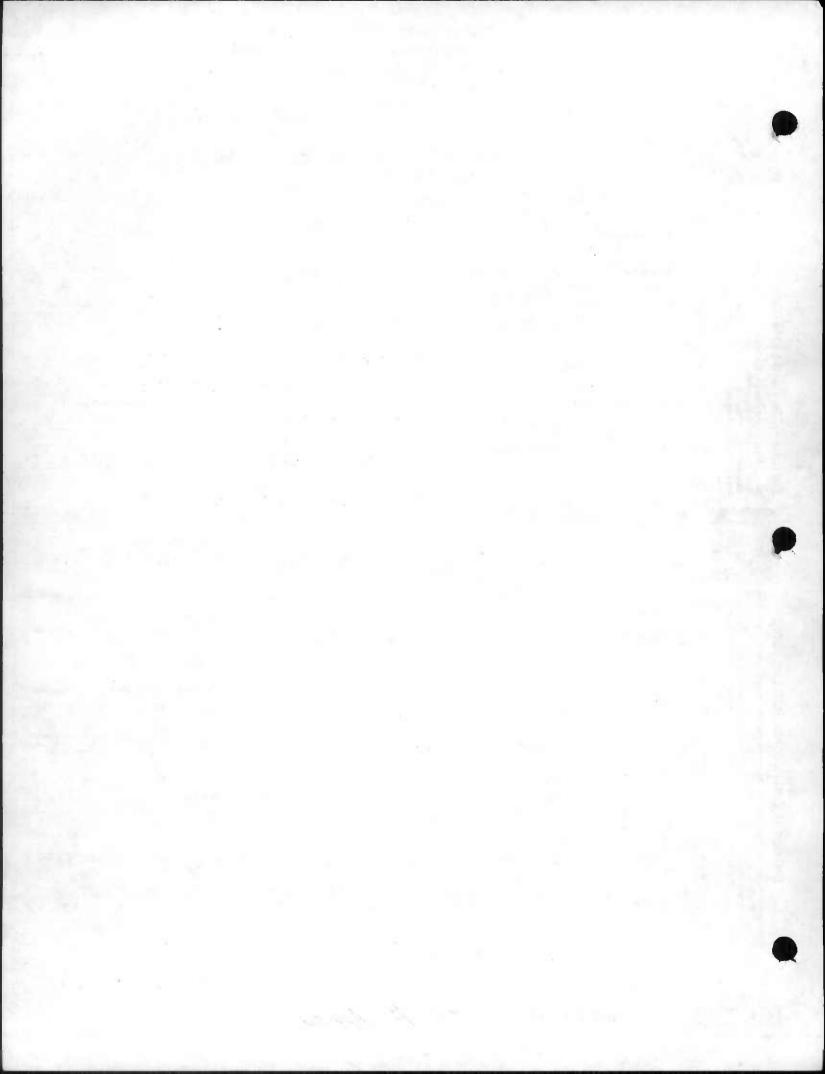
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Tima of Death Year **Physician** Irene C. Hopkins 1:30 PM 22nd 2000 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 6-8-1913 Birthplace (State or Foreign Country)
 De . 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Days Yrs 220-26-3065 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or flems 23s or 28s-f show other traumade event, the Madical Examinar must be notified at X□Yes 2□No Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Booth St. 21801 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth eny Injury or other traumatic event Bates. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Phillips Laura Hastings Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura Culver, Daughter P.O.Box 149 Hebron, Md. 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 1-25-00 Hebron, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. Milion 13 E. Grove St. Delmar, De. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician iovascular Desce /Medical Immediate Cause (Final disease or condition resulting in death) Examiner physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed mus 1 Yes 2 No 1 ☐ Yes 2 No Division of VItal after death.

Director: After this certifications 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or A
 24 hours after
 Funeral Dire
 ietaly filled in b 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man D 29505 1-24-2000 regery Mori 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO M-31. Date filed (Month, Day, Year) 32. Registrar's Signatur State JAN 24 2000 Lin, iron in Registrar

DHMH 16 Rev 6/95

HUPKINS



### Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie	ne
Contificate of Dooth	

			State of Marylan		rtment of I			giene Reg. No.	0 062	61		
		1. Decedent's Nama (First, Middle, La	st)				2. Date of De		3. Tima o	f Death		
	Physician	Martin	Francis	Holle	arn		Month	Day	Year	E1		
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	Examiner		2 3 4 4 4									
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Aand	ě m	10a. Sfata 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside C	ity Limits		
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the	128	10e. Street and Number	32		10f. Zip Code			10g. Citizen of W	/hat Country?			
Will	O D	10311 Twin Oal	ks Road NW			21502		USA				
d 21215-0020 filed within 72 hours effer death with the Meryland Hygiene.	7 is marked other than "natural", or items 23s or 23s-f show traumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13. W	as Decedent of	Hispanic Origin? (S	Specify Yes or No		- Amarican Indian,			
the C	5 E	1 Nevar Married 2 Married	Armed Forcas? 1 X Yas 2 ☐ No			an, Mexican, Puar	to Rican, etc.)		k, Whita, atc.			
21215-0020 d within 72 hours ef giene.	by by	3 Widowed 4 Divorced	If Yas, Give Yaar or Datas: WW I	I 1	☐ Yes 2☐ No	Specify:		Specify:	white			
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ylan Wentel	P S S	Francis Holler	cn			Doreth	ia (B	ortman	)			
laryland 2 should be file and Mentel Hy		t9e. Informant's Name/Ralationship (				t and Number or Re						
6 -	U F	Catherine M. H	Hollern	1031	l Twin	Oaks Ro	ad; Cum	berland	d MD 21	502		
	E	20a. Memod of Disposition	20b. F	lace of Dispos	ition (Name of atory or other ple	ocal I	Dete	20c. Location -	City or Town, Stata			
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Balt permit. Departr	any ir	Makala	h a ana (10)			Ti Fariane						
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	-	23a. Part1. Entar the disaasa, or com shock, or haart failura. List only	receuse on each line.	n. Do not enta	r tha moda or dy	ng, such es cardia	c or respiratory a	rrast,	Approxima Intarval Be Onset and	tween		
	sician	leading Court (Final							)	Death		
	edical miner	Immediata Cause (Finel disease or condition rasulting in daath)	a. Respiratory	Failu	ce				1 wee	ek		
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D	n and ial-transit Examiner		b. Severe Emph	ysema					l yea:	r		
Bout	tran	Sequentially list conditions, if any, leeding to immadiata	Due to (o	r as a consequ	ience of):							
, 50°	clan Suria	rany, leading to immadiate cause. Enter Undarrying Couse (Disease or injury c.										
. Box 68760, death certificate be executed	stending physician and for use as the bunal-transit clan/Medical Examir	that initiated evants rasulting in death) Last  Dua to (or as a consequence of):										
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88 #	b g	Coronary Artery	Disease, Diane	tes Me.	LIIEUS,							
VITAL RECORDS, P.O.	cate has been signed by the attending p , page 2 should be detached for use as Completed by Physician/Mee	Umartanaian						an autopsy rmed?	24b. Wara eutopsy available prior	to		
a ec	has be pe 2 sh mpie	Hypertension							completion of of death?	cause		
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= =	ral director, page To Be Co	25. Was casa referred to medical				26. Place of De	ath (Check only	ona)				
Of Vita Physician:	To E	axaminar? 1 Yas 2 No	Hospital: 1 Lunpatient 2	ER/Outpatient	3 DOA O	her: 4 Nursing F	toma 5 ☐ Resi	dence 6 Othe	er (Specify)			
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DIVISION or Attending	al Diractor: After the led in by the funeral Certification: 1	3 Suicida 8 Could not be 4 Homicida determined	28a. Place of Injury - At he	oma, farm, stre	ef, factory, office	13			er or Rural Routa Nur	nber.		
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To the Hospital o within 24 hours af	y fille		yelcian: To the best of my kno									
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To th withir	To the	29b. Signatura and title of certifiar	2		29c. Licen	se number		29d. Data signed	(Month, Dey, Year)			
	7	Homax	earl MI	)	n/.	6346		T -	- 01 0000			
	6	30. Nama and address of person who	completed cause of death /Item	23a) (Type 5	1	0240		January	7 31, 2000			
	5					C	aland M	D 21502				
100	State	Dr. Huma Shakil, 31. Data filed (Month, Day, Year)	Johnson Height 32. Registrar's Signa		ar prog	., cumber	Liand, M	D 21502				
F	State Registrar	JAN 3 1 20			1	1						
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DHMH 16 Rev 6/95

JAN 3 1 3020 January 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month February 6:22 am Dortha E. Hartsock 3 2000 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Cumberland Nursing Home Cumberland, MD Allegany if Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
June 03, 1912 Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 3√2 F Months Deys Yrs. Director 220-16-7112 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Cumberland, MD Allegany MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6 238 permit. Peges 1 end 2 should be filed within 72 hours efter deeth 1 Department of Heelth and Mental Hygiana. Important: If Itam 27 Is marked other than "natural", or flams 23a any Injury or other traumatic event, the Medical Example research. 21502 USA 220 Somerville Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie (Richards) Growden Levi Ellsworth Growden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Sunset Dr., LaVale, MD 21502 C. Edward Hartsock 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stele 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fellowship Cemetery Centerville, PA Donation 5 Other (Specify) 2/5/00 22. Name and Address of Facility Right Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. **Physician** /Medical Immediale Cause (Final Assiration mounts disease or condition resulting in death) Examiner Examiner sician and buriel-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of): esn signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 ONo 3 ☐ Probably 4 ☐ Unknown Deligheatin Be Completed by 24a. Was an eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ inpalien1 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Aftar Natural 5 Pending Investigation eftar death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours Medicai 29a. Certifier Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. within 24 ho To the Fune completely fi (Check only one) ş 5

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State Registrar

82. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

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SCHLEY ST, Cumberland, Rd 21502

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State of Maryland / Department of Health and Mental Hygiene

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	9 6	Funeral	11. Marital Status		12. Was De	ecedent Ever in Forces?	U,S. 13.	Was Decedent	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yas or No			can Indian,	
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O	After Fund		1 ⊠Natural	5 Pending		a of Injury onth, Day Year)	Injury		Injury at Work? 1 Yes 2 No			-		
Division	dear dear	100	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could r	ot be 28e. Pla	ce of Injury - At	homa, farm, at					ber or Rui	ral Route Number,	
á	and in it	Certification:	4 Homicide	55.57111	buil	ding, etc. (Spec	city)			City or To	wn, Stete)			
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	1000	+	30. Name and addr	ass of nareon	who completed ca	use of death /te	9 F/4	Print)						
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DHMH 16 Rev 6/95

State Registrar

158 0 7 2000 James B Spirite

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Charlotte Elizabeth Jenkins January 29, 2000 8:00 pm 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death College View Center of Frederick Frederick Frederick If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days 1 M 2 XF 578-03-3166 Oct 24, 1918 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Nes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1604 West 7th Street 21702 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Services 11 Education 17. Fathar's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Raymond B Watson Elizabeth Bradburn 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18620 Orchard Hills Pkwy, Hagerstown, Maryland 21742 Loc of Disposition (Name of Dete 20c. Location - City or Town, State Charlotte L. Leaman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft Lincoln Cemetery Feb 3,2000 Brentwood, Maryland 21. Signatura Tuneral Service License 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 E Church Street, Frederick, Maryland 21701 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 month disease or condition resulting in death) Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical **Examiner** 

Examiner

Physician/Medicai

by

Completed

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Certification:

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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altimore, Maryland 21215-0020

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Department of Health and Mental Hype any Injury or other.

Director

Funeral

Completed

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physician and the burial-transit 8 g page 2 this in 24 hours after death.

• Funeral Director: After etely filled in by the After Attending

Box 68760

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Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hirenkumar 170

Thomas Thonson

1 ☐ Yes 2 ☐ No

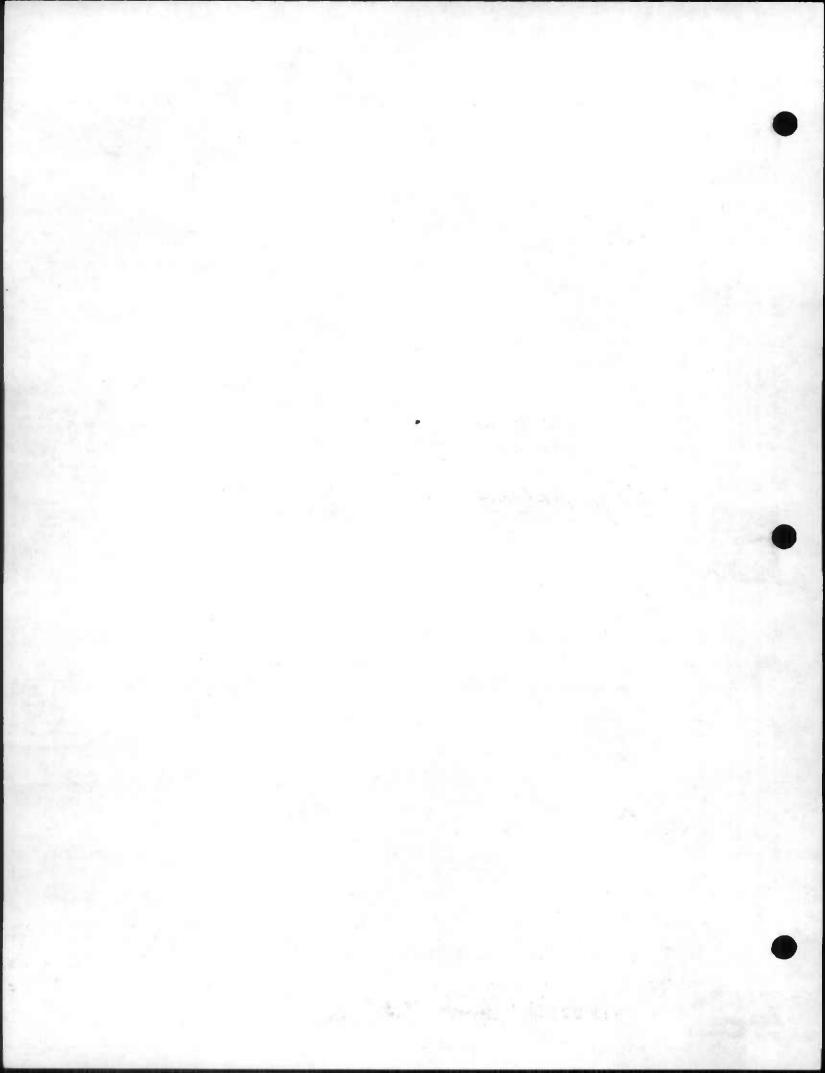
State Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2000



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death brh Amend item#1 HCHD 02-10-00 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** :50PM - WHAN Ruth Cornelia Julian DD /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltinore

Wunder 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 28, 19 Cromwell Center - Genesis Elder Care Baltimore Baltimore If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 35/F 1918 Maryland Director 215-07-7971 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 20 No Directo Baltimore Perry Hall 288-1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21128 USA Berns 23a 4610 Forge Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 N Married Baitimore, Maryland 21215-0020 'natural', or 1 Yes XXNn Specify PV 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumerne) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nearl of Health and Mental Albert (u/k)Hoffman Effie (u/k)Keithley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Department of Health ar Important: If them 27 is any Injury or other trau Ralph Julian - Husband 4610 Forge Road, Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 2/8/00 Calvary U.M Church Cem. Churchville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21 Signature of Funeral Service Licensee McComas Funeral Home, P.A. 23a. Pert1. Enfor the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

App. App. 21009 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final PROGRESSIVE SUPRA HUCLEAR disease or condition resulting in death) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of): Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown TEMSION Records, py 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed The law 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) To Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Affect 1 2 Naturet 5 Pending investigation 1 | Yes 2 | No 2 Accident after death 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 8 24 hours Funeral edical 112 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29a, Certifier (Check only within 2 onel To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

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31. Dete filed (Month, Day, Year)

FEB 1 0 2000

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18HADDIYA MD 3007 E. MORTHERN PKWY

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

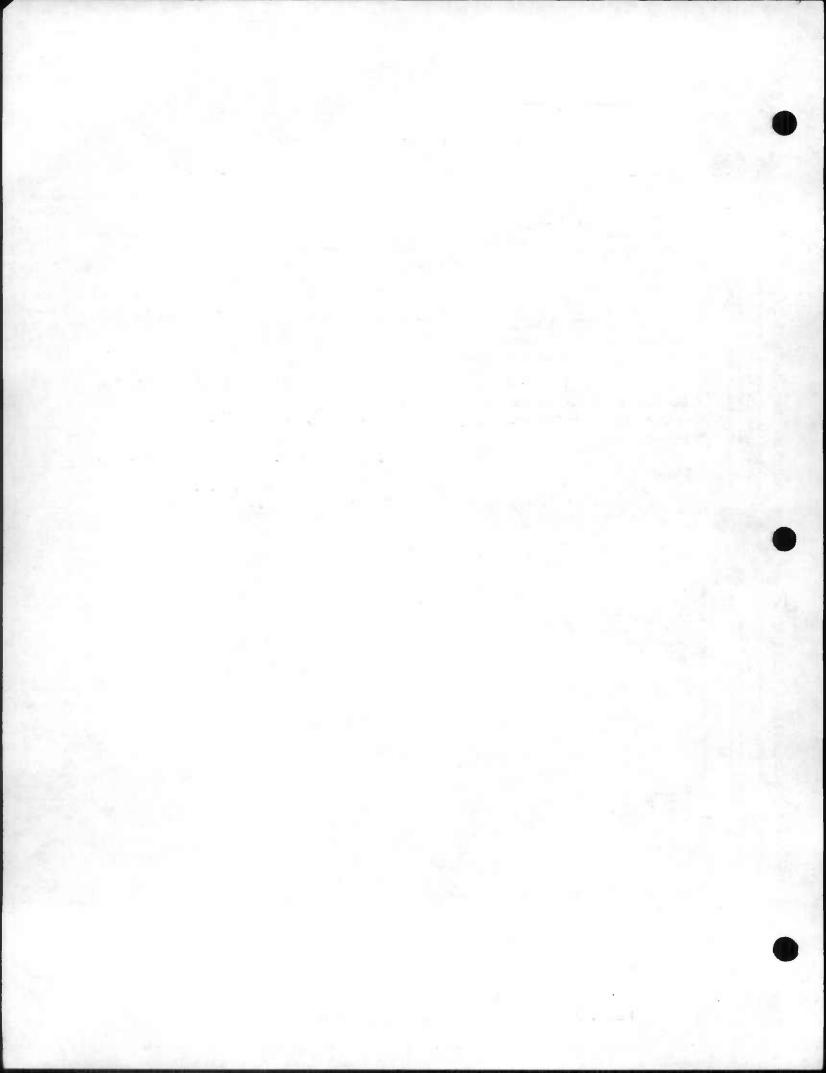
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SALTIMORE-

MD 21214



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Des Year **Physician** Emma Elizabeth Johnson JAN 2000 26 /Medical 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Daeth Examiner Good Samaritan Hospital Baltimore Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 M XX F Months 237-09-2229 Director 87 4-25-1912 N.C. Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Director Md. Anne Arundel Glen Burnie must be notifie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 327 Argus Lane 21061 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mertal Hygion important: if then 27 is marked other the Homemaker Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be T. A. Hill Bertha Steed Hill 19e. Informant's Neme/Reletionship (Type, Print)
Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Terry Lynn deLorge, 327 Argus Lane, Glen Burnie, daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriat 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Stephens Cemetery 1-29-00 Delmar, De. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Short Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, À 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? peeu 1 ☐ Yes 200No 2 7No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2DRNo Lo 1 Shpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Beath 28d. Describe how injury occurred 28h Time of he Hospital or Attending P in 24 hours after death.

The Funeral Director: After the pletely filled in by the funeral Certification: 28c. Injury at Work? Affer 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide Descritifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of couling 29c. License number D18587 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) BAUTIMERE MD 900 GORMC

DHMH 16 Rav 6/95

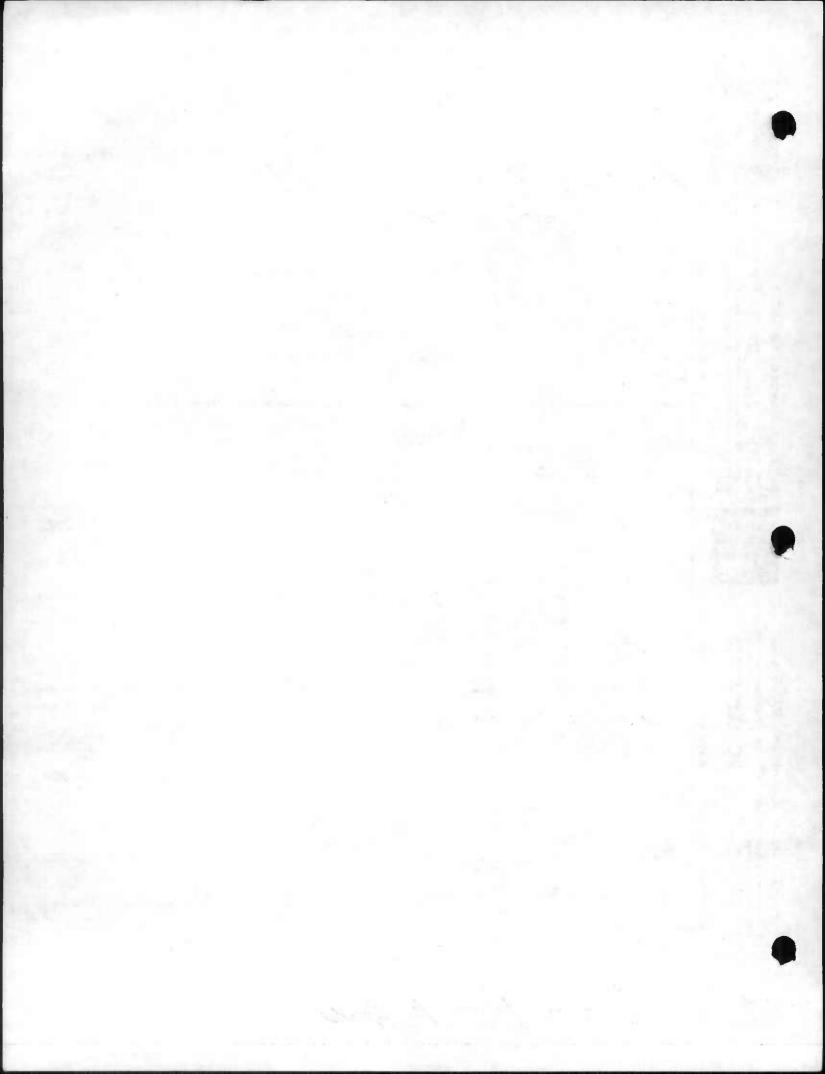
State

Registrar

31. Dete filed (Month, Day, Year)

JAN 2 7 2000

32/Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Vear **Physician** Tohnson Fla 10:30AM JANUARY 24 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. A BALTIMORE CITY If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF Director 218-24-5991 76 March 26,1923 MD Usual Residence of Decedent 10a. State 10b County 10c City Town or Location r 23a-f show notified at 10d. Inside City Limits 1X Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 1103 Tuscola Avenue "natural", or flams 23a 21801 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If them 27 is merited other the
any Injury or other traumetic 7th Laborer unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Oliver Collier Rena Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Dulaney Ave., Fruitland, MD 21826 Homer F. Bounds, Jr./son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/00 Green Acres Mem Park Salisbury, MD 21. Signature of Funeral Service Licente 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a Part1 Enter the clamase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, black or heart felture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Hidney disease 5 months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner diabetes mellitus 10 years physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Imonth Box 68760 Infection Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 212 No 3 Probably 4 Unknown 1 Yes by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 0 NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) axaminer? Hospital: 1 Unpatient 2 EFVOutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Alatural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) RES-000 January 24, 2000 all

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 7 2000

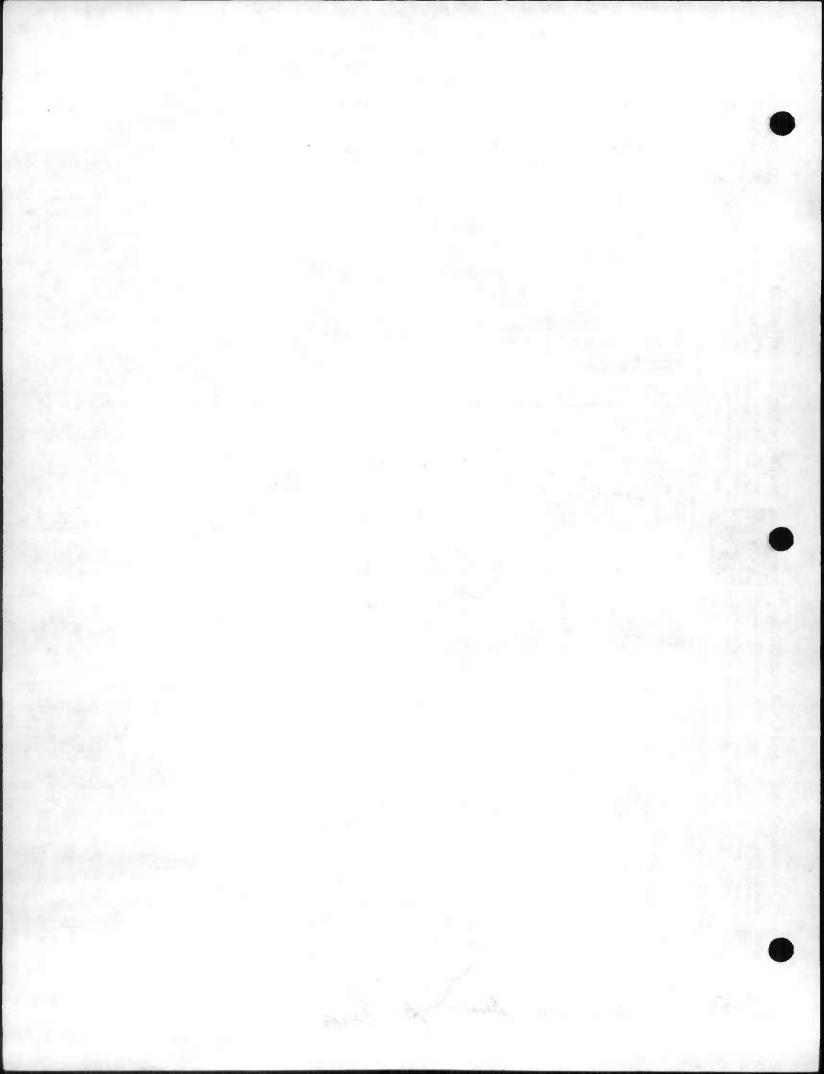
32. 969

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dee Walker-Ford, 110 Tower Building

32. Pegistrar's Signature

Baltimore, Maryland 21205



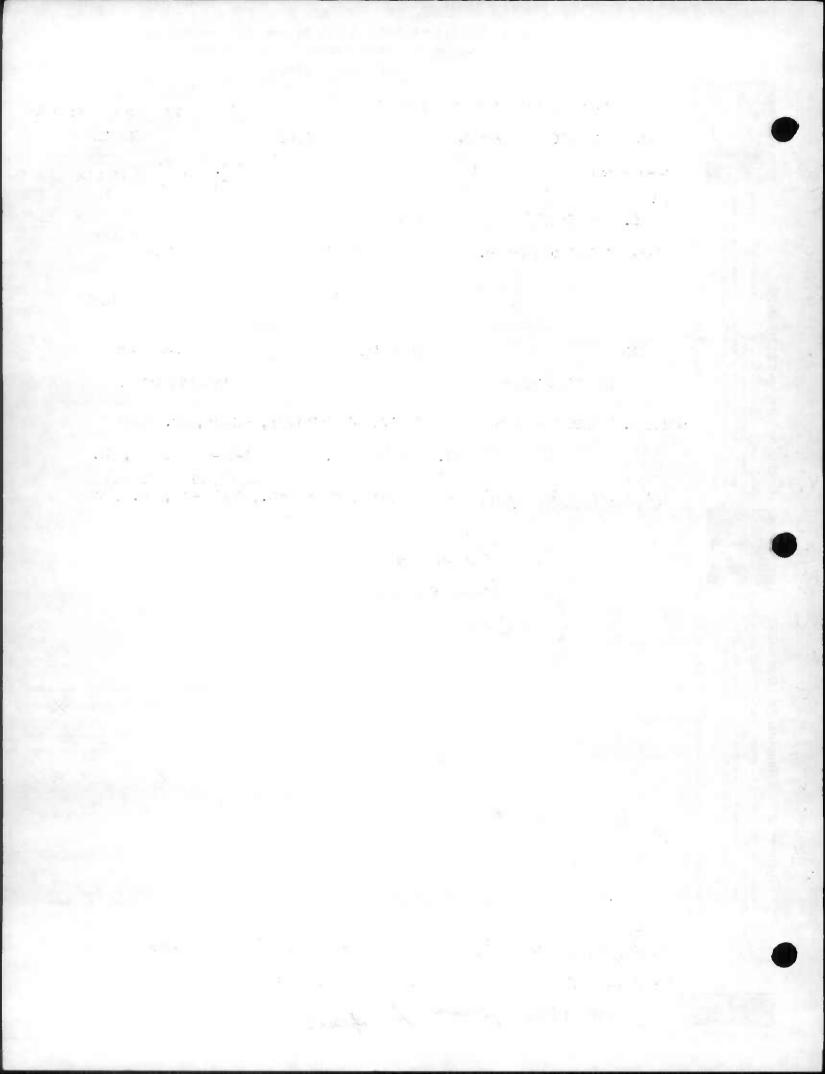
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month Day Year **Physician** LENA ELIZABETH MORRIS JOHNSON 9 2000 4c. County of Deeth 4:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | SEP | 27, 1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 91 218-34-8185 Director BERLIN Usual Residence of Decedent with the Merylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD. WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? res 23a or 21811 USA 92924 BOTTLE BRANCH RD. Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 7 is marked other than "nature traumatic event, the Mapical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "I any injury or other traumatic event, the Max. Elemantary/Secondary (0-12) 7th Collaga (1-4or 5+) DOMESTIC HOUSEWORK 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) GEORGE JOHNSON CAROLINA TINGLE 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 108223 REDWOOD LANE, BERLIN, MD. 21811 HAZEL P. BRIDDELL/DAUGHTER 20b. Place of Disposition (Name of comatery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Cremation 3 Removal from State ST. PAUL UMC CEM. 1 - 24 - 0BERLIN. MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD., SALISBURY, MD. 21801 23a. Pert1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each live Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition rasulting in daath) TREUMOWIA Examiner Due to (or as a consaguanca of) Examiner ENAL Fulleno physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Lest Due to (or as e consequenca of) Physician/Medical Due to (or as a consequance of) SBS esn ohnson, Leng 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of daath? 24a. Was en eutopsy performed? Completed page 2 s 2 No 1 ☐ Yes 2 No 25. Was casa rafarrad to medical axeminar? Be 26. Place of Death (Chack only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Panding Investigation 1 Naturai 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homlcide 24 hours McCertifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 H005374 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 5 Healthway DRIVE 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State JAW 2 4 2000 Registrar Sporks

**DHMH 16 Rev 6/95** 

430

1/19/00



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dey Year FOSKEY W JOSEPH JANYANY 22, 2000 2115 4a Facility Neme (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 4b. City. Town, or Location of Deeth 4c. County of Deeth WICOMICO SALISBURY If Under 1 Yeer | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Dete of Birth (Month, Day, Year) Aug. 17 1914 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 215-03-3281 85 Usuel Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 129 North Park Drive U.S.A 21804 12. Was Decedent Ever in U,S. Armed Forces? 1 Xyes 2 No 1Yes, Giva Year or Detes: ₩₩ 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Joseph Mary Molly Jones 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 129 North Park DR.Salisbury, Md. 21804 Bonnie Molock (Daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State 128/00 Md. Veteran Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Hurlock, Md. 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Stewart Funeral Home Gladys B. Stewart 821 West Rd.Salisbury, Md.21801 23a. Pert1. Enter the pissess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset end Death Immediate Causa (Final disease or condition resulting in deeth) Yneumonia Vancreatre Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy tindings evailable prior to completion of cause of death? 24a. Wes an eutopsy 1 Yes 2 No 1 Yes 2 No 26. Placa of Death (Check only ona) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760, Physician/Medical USB AS been signed by the should be detached Records, þ Completed page 2 certificate Division of Vital or Attanding Physician: funeral director, Be Certification: To this ne Hoepital or Attanding n 24 hours after death. filled in by

**Physician** 

/Medical

Examiner

Directo

Funeral

P

Completed

**Funeral** 

**Director** 

23a or

b

21215-0020

Maryland

altimore,

filed within

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygae Important. If Item 27 is marked other th any Injury or other traumatic event, the 2008.

**Physician** 

/Medical Examiner

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25. Wes case reterred to medical axaminer? 27. Manner of Death 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28a. Plece of Injury - At home, term, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only ane) 29b. Signative and trib a ceptio

29c. License number 29d. Date signed (Month, Day, Year) 23

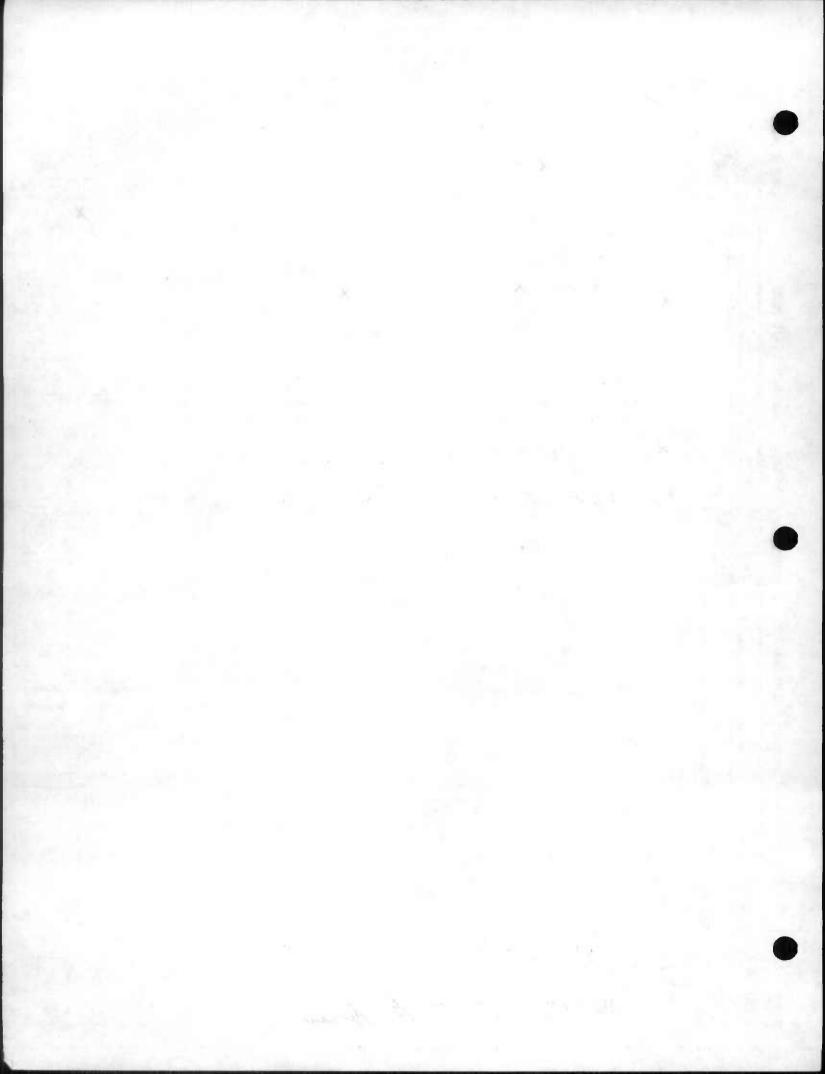
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

LOG MUFORD ST SUITE ZOL SPRUSBLEY MY ZIECH MITCHOL S. GITTERMAN, DO 31. Dete tiled (Month Car Y2) 4 2000

State Registrar

Medical

To the Hosp within 24 ho To the Fune completely f



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death Year **Physician** 5:40 AM February 13 2000 /Medical 4a Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Johns Hopkins Hospital 5. Sociel Security Number If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign September 11, 1912 Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Hours 10XM 20 F Yrs. Director 214-14-2344 Usual Residance of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 No Director 23s or 28s-f Maryland ST. Marys Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21191 Three Notch Road 20653 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 11. Merital Status 1 X as 2 No If Yes, Give Yeer or Dates 1945 1 Never Merried 2 Married ð Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify:Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Federal Government Motor Vehicle Operator 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be filtered of Health and Mental Hamt. If Hern 27 is marked off jury or other traumatic even Be Augusta Brooks Daniel Webster Kent 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21191 Three Notch Rd. Lexington Park, Maryland 20653 Carrie Kent-Wife 20b. Pleca of Disposition (Name of cametery, cramatory or other place) 20a, Method of Disposition 2/22/00 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ramoval from Stata Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility M00191 Adams Funeral Home P.A. Aquasco, Maryland 20608 23a. Part 1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one cause on each line. Approximete intervet Between Onset end Death **Physician** /Medical tmmediate Cause (Final Dermato ingositis 2-5 months disease or condition resulting in deeth) Examiner Examiner Ischemic cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of) The law requires that the death certificate be execu Box 68760. Dysphagla Due to (or as a consequence of): Physician/Medical P.O. Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examinar? edical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide

s after death. To the Hospital o within 24 hours af To the Funeral DI completely filled is

relance lange 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Marcus Cooper, Johns Hopkins Haspital, Tower 110, Poctors Lounge, 600 M. Wolfe St, Bultimore, MO 21287

31. Dete tited (Month, Day, Year)

FEB 16 2000

Service B. Sporks

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at tha time, date end place, and due to the cause(s)

29c. License number

RES-000

29d. Data signed (Month, Day, Year)

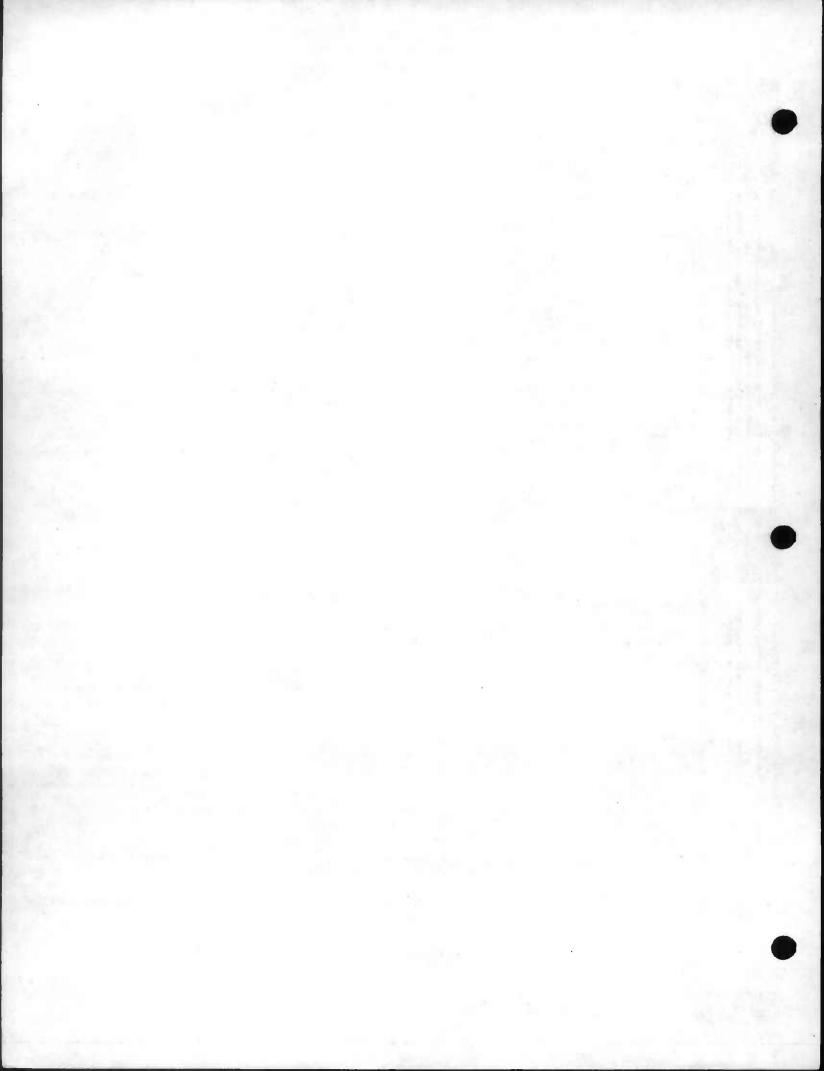
2000

February 13,

29a, Certifier (Check only one)

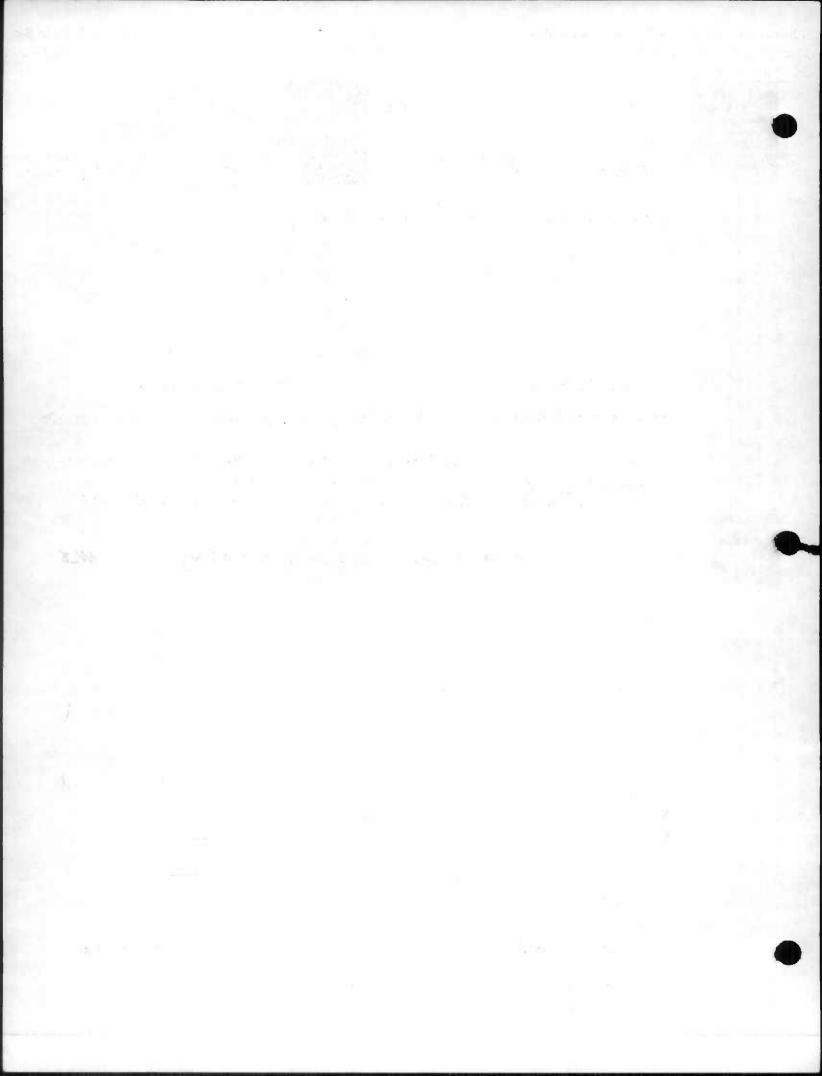
29b. Signatura and titla of certifier

end menner steted.



1	Phy /M Exa	sician edical iminer
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.	To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be dateched for use as the buriel-transit

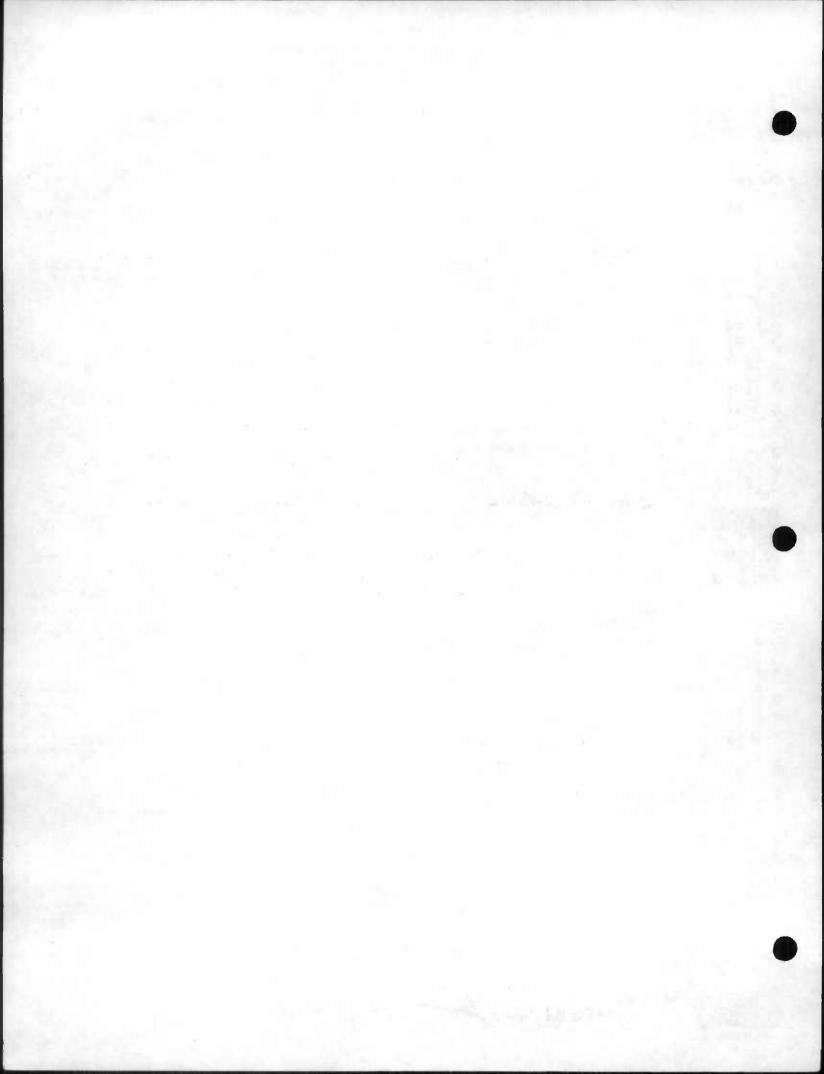
4a. Fecility Neme (II not institution, give street end number)  St. Mary's Hospital  5. Sociel Security Number  6. Sex  1 Months  6. Sex  7. Age (In yrs. lest birthday)  62 Yrs.  Months  Days  Hours  Min.  Sept. 12, 193  Usuel Residence of Decedent  10a. Stete  10b. County  Maryland  St. Mary's  10c. City, Town or Location  Charlotte Hall  10c. Street and Number  30305 Pine Street  10g. Citize  30305 Pine Street  11. Was Decedent Ever in U.S.  Armed Forces?  11. Maritel Status  11. Never Married 20 Married  3   Widowed 4   Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, Give Year or Dates:  14. Yes, specify Cuben, Mexican, Puerto Rican, etc.)  15. Decedent's Education  (Specify only highest grade completed)  Elementery/Secondary (0-12)  15. Decedent's Education  (Specify only highest grade completed)  Elementery/Secondary (0-12)  16e. Decedent's Usuel Occupation  (Give Kind of work done during most of working life. Do NOT use relified)  Homemaker  18. Mother's Neme (First, Middle, Meiden St. Lillian G. Washi  19e. Informant's Neme/Belationship (Tyme Print)  19e. Informant's Neme/Belationship (Tyme Print)	3. Time of Deeth 9:27 AM county of Deeth 5t. Mary s 9. Birthplece (State or Foreign County) Washington, D.  10d. inside City Limit 1 Yes 2 N N en of Whet Country? .S.A.
St. Mary's Hospital  St. Sociel Security Number  5. Sociel Security Number  6. Sex  1 Months  1 Months  6. Sex  1 Months  1 M	9. Birthpiece (State or Foreign Country) Washington, D.  10d. Inside City Limit 1 Yes 2 NN en of Whet Country?
5. Social Security Number 579-46-7580    Sex   1	9. Birthplece (State or Foreign Vashington, D.  10d. Inside City Limit  1 □ Yes 2 N N  an of Whet Country?
Usuel Residence of Decedent  10a. Stete  10b. County  10c. City, Town or Location  Charlotte Hall  10a. Stete and Number  30305 Pine Street  10b. County  10c. City, Town or Location  Charlotte Hall  10c. Street end Number  30305 Pine Street  10c. City, Town or Location  Charlotte Hall  10c. City Town or Location  10d. City Town or Location  Charlotte Hall  10d. Zip Code  20622  U  11. Maritel Status  1 Never Married 2 (X) Married  1 Never Married 2 (X) Marri	10d. Inside City Limit 1 ☐ Yes 2 💢 N en of Whet Country?
10a. Stete   10b. County   10c. City, Town or Location	1 ☐ Yes 2 🕅 N
10e. Street end Number 30305 Pine Street  10f. Zip Code 20622  11. Maritel Status 1 Never Married 2 Married	1 ☐ Yes 2 🕅 N
3 Widowed 4 Divorced If Yes, Give 1  1 Yes 2 Q No Specify:  1 Yes 2 Q No Specify:  S  S  1 Yes 2 Q No Specify:  S  1 Yes 2 Q No Specify:  S  S  1 Yes 2 Q No Specify:  S  S  S  S  S  1 Yes 2 Q No Specify:  S  S  S  1 Yes 2 Q No Specify:  S  S  S  S  S  S  S  S  S  S  S  S  S	
3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  17. Fether's Neme (First, Middle, Last)  Joshua F. Davis  19. Meiling Address (Street and Number of Purel Point)  19. Meiling Address (Street and Number of Purel Point) Number of Purel Point Number of Purel P	.S.A.
Joshua F. Davis  Lillian G. Washi  199 Informent's Neme/Relationship (Type Print)  190 Meilling Address (Street and Number of Purel Route Number of Purel	t. Race - American Indien, Bieck, White, etc. Specify: White
Joshua F. Davis  Lillian G. Washi  19. Informent's Neme/Relationship (Type Print)  19. Informent's Neme/Relationship (Type Print)	d of Business/Industry
Cosnua r. Davis Lillian G. Washi	
19e Informent's Neme/Rejetionship (Tyme Print)	ngton
John J. Kendrick/Husband 30305 Pine Street, Charlotte Hall	
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Local	ation - City or Town, Stete
1 M Burial 2 Cremation 3 Remove from State 4 Donation 5 Other Special Maryland Veterans Cem. 02-15-2000 Che	
21. Signature of Facility The Huntt Funeral Home, Inc. W JOHN P. KNISLEY M01164 P.O. Box 156, Waldorf, Maryl	
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.	Approximete intervel Between
Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest  Due to (or es e consequence of):	yk,
Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.  23b. Did tobacco us	sa contribute to the cause of deat
	No 3 Probably Unkno
24a. Wes en eutopsy performed?	y 24b. Were eutopsy findings evaileble prior to completion of cause of death?
1 □ Yes 2 D	No 1 Yes 2 No
25. Wes case referred to medical exeminer?  26. Place of Deeth (Check only one)	
Comparison   Com	
27. Manper of Deeth 1 Natural 28e. Date of Injury 3 Suicide 4 Homicide 28e. Pieca of Injury - At home, farm, street, factory, office 28e. Date of Injury 3 Sec. Injury et 38e. Date of Injury 38e. Date of Injury 48e. Date of Injury 48e. Date of Injury 48e. Date of Injury 58e. Date of Injury 68e. Date of Inj	Number or Rurel Route Number,
	signed (Month, Day, Year)
29e Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) at Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piend manner stated.	
29e. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) et Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piend manner stated.	-14-00



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	L			Otate of W	arylari		ificate of	Death	Wichtairry	Reg. No.	) ()	6272
Physici /Medic		Decedent's Name			ARGAR	RET KNO	OX		2. Dete of De Month FEBRU	Day	Year	3. Time of Death 12:15 P.M.
Examir		4a Facility Name (#	not institution, giv	re street end number,				4b. City, Town, or	Location of Deat	h 4c. Count	y of Death	
		17310 N 5. Social Security No		VIEW RD.	na (In una I	last birthdey)	If Under 1 Year	EMMITSBU If Under 24 Hrs			DERIC	
Funeral Director		214-42-09 Usual Residence of	970	I M 2 X F	93		Months Days	Hours Min.	(Month, De	25,1906	FINK	place (State or Foreign ntry) SBURG, MD.
Die Marie		10a. State	10b. County		10c. City	y, Town or Loca	ation					10d. Inside City Limits
e Mar	ctor	MARYLAND	FREDER	CK	EM	MITSBUR	RG					1 ☐ Yes 2 🕅 No
Milton De no	Directo	10e. Street and Num					10f. Zip Code			10g. Citizen of		
re 23	Funeral	1/310 N	MOUNTAIN	VIEW RD.	Ever in U.	S. 13. Wa	2172 as Decedent of h		pecify Yes or No	The state of the s	S. A	can Indien,
ors after of the Examines	by Fun		ed 2 Married	Armed Forces'  1 Yes 2 X  If Yes, Give Yeer or Detes:	,		res, specify Cub ☐ Yes 2 () No	dispanic Origin? (Sen, Mexican, Puerl Specify:	o Rican, etc.)	Special Special	ck, White,	
5-0	pete		15. Decedent's Edity only highest gra			(Give kii	nt's Usual Occup	during most of wor	rkina	16b. Kind of E		
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D The State of the	Be Co	17. Father's Neme (	First, Middle, Last,	)		CAFEIL	ERIA DEP	18. Mother's Nar	ne (First, Middle	PUBLIC , Maiden Sumei		UL S
/lan Wental Mental rikad o	ToB	THOM	MAS BAUMO	GARDNER					NINA MO	ORRISON		
2 she and to me		19e. informent's Ne						end Number or Ru				
1 and 1 and Health Pm 27 ther 1		POLLY ANN 20a. Method of Disp		AUGHTER	20b. Pl	17310		N VIEW R	D., EMM	ITSBURG,		
Pages 1.		1 Burial 2		Removal from Stete	CE	emetery, creme	tory or other ple					
alti mir. i partm porter y injur		21. Signatore of Fur		*	NE		Neme and Addre	EMTery 2 pss of Fecility		KEYSVIL		
n salsa		D Jak	m	Skiles		210	W. MAI	N ST., E		FUNERAL RG. MD.		
Physician		23a. P. 11. Enter the	e disease, or com t failure. List only	plications that cause one ceuse on each I	d the deeth						0 1 1	Approximate interval Between Onset and Death
/Medical Examiner		immediate Cause (I disease or condition resulting in death)	Finel	· Usa	he	me	Cau	dion	you	attr	8	2 yr
	Jer			00	Due to (or	r es a conseque	ence of):	# 1	000		3	710
be executed sician and bunial-transit	Examiner	Sequentially list con	ditions,	6.	Due to (or	as a conseque	ance of):	were	rece	www		a yes
be ever	cal Ex	Sequentially list con if any, leeding to im- cause. Enter Under Ceuse (Disease or i	mediete tying njury	C							į	45 - 4
Phys the	8	that initieted events resulting in death) L			Due to (or	as a conseque	ince of):					
death certification of for use as	an			d								
. 0 0 %	ysici	Pert II. Other signific	cant conditions c	ontributing to death b	ut not resu	ilting in the und	erlying cause giv	ven in Pert I.	23b. Did	tobacco uss co	ontributs t	to the causs of death?
res that the designed by the a	by Physician/M	Sin	Il I	emer	tu	u	rith		10	Yes 2 No	3 Pro	obably 4 Unknown
requi been should	Completed b	9	ene	olized	M	uscl	e wa	stry		an autopsy ormed?	ev Cd	Vere autopsy tindings valleble prior to propertion of cause death?
The law ate has be page 2 s	ошь			0				0	10	Yes 20 No		☐ Yes 2☐ No
yatclan: The s certificate director, pag	Be C	25. Was case referre	ed to medical					26. Place of De				14
- L .0 0	2	1□ Yes 2□x		Hospital: 1 Inpati		ER/Outpatient	3LI DOA		lome 5 Resi			(fy)
JING Phy h. After this funeral d	lon:	27. Manner of Death 1 XNatural	5 Pending investigation	28a. Date of Inju	y Year)	28b. Time of Injury	28c. Inju	ryat rk?  Yes 2 □ No	28d. Describe	how Injury occu	rred	
or Attendent there deat the deat the deat the deat the deat the the deat th	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At ho c. (Specify	me, farm, stree		100 2010	28f. Location ( City or To		ber or Rur	el Route Number,
To the Hospital or Attending Ph within L24 hours diet death. To the Funeral Director: After thi completely filled in by the funeral	edical Co	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner: On the basis o	examineti	viedge, death o ion end/or inves	occurred at the til stigation, in my o	me, date and place opinion, death occu	, end due to the pred at the time,	cause(s) end m date and plece	enner as :	stated. to the cause(s)
To the To the Somple	M	29b. Signature and t	itle of certifier			04.	29c. Licens	se number		29d. Date sign	ed (Month,	Dey, Year)
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				completed cause of o				MATTER LINE	110 0	1707		
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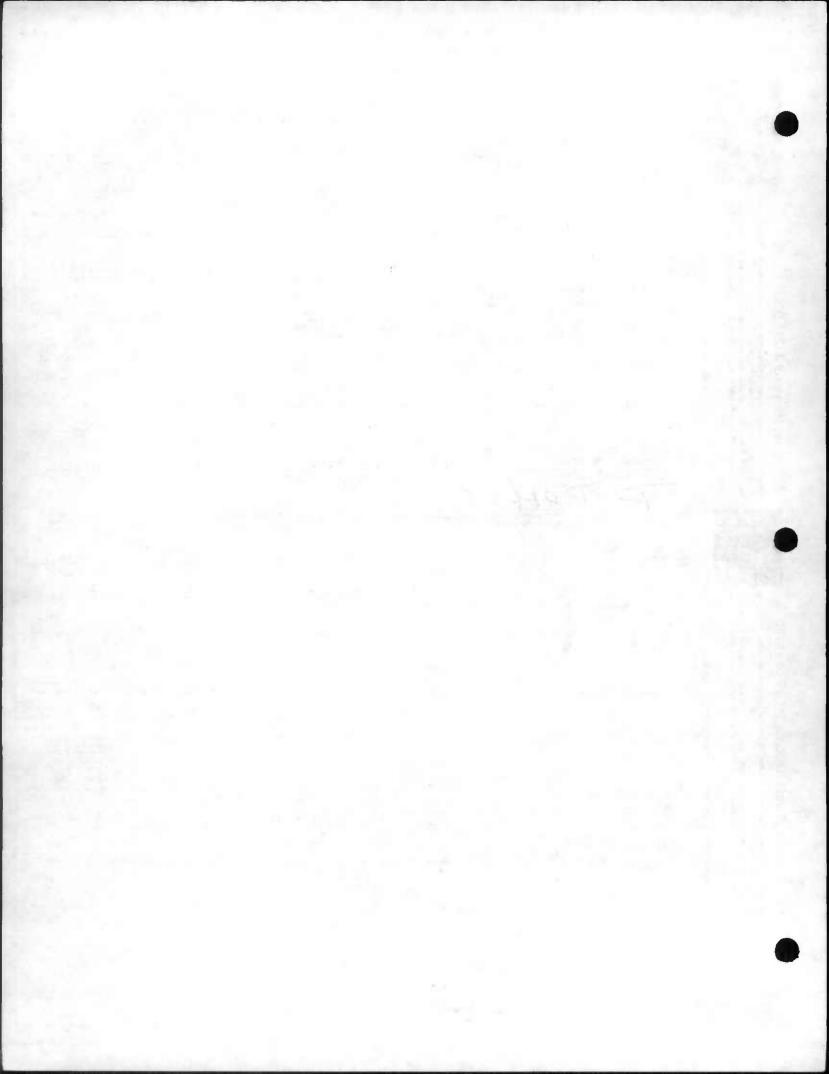
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Year **Physician** EDITH V. KLINEJOHN FEBRUARY 2000 5, 3:30 PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GLADE VALLEY NURSING & REHABILITATION CTR. WALKERSVILLE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2♥F Yes 91 Director Virginia 219-42-1819 Dec 12, 1908 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 No Yes 2 No Directo Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 100 Burgess Hill Way 21702 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Status filed within 72 hours after Hygiene. other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 No Specify: Specify: white P 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if Nam 27 Ia marked other th any Injury or other traumatic avant, the page. 10 Homemaker self 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be King William White Ocie Baughan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Jones / daughter 2907 Bidle Road, Middletown, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GardensofFaithMemGardens 2/8/00 Baltimore, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 3B 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused shock, or heert lailure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final Pneumonia Aspiration Iheal diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): 1 week Vascular Acciden physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use as USA ed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Dementa by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen has 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funaral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending investigation 1 | Yes 2 | No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29c. License number 29d Date signed (Month, Dey, Year) 29b. Signeture end title of certifie D43091 2-7-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK 801 104 HOUSE TAIDI MD SACED 32. Registra s Signatura 31. Dete liled (Month, Day, Year) State oaks FEB 0 8 2000 Registrar



# Baitimore, Maryland 21215-0020

CAROLINE KELLY

Please Type or Print in Black I	Indelible Ink.	Assure All	Copies Ar	e Legibie

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

					ei iiiica	ne o	i De	aur			Reg. No.			
1. Decedent's Neme (First, a Caroline J	. Kel	1у								2. Date of De- Month FEBRUAL	RY 06,	2000°		ma of Death
4a Facility Name (If not Inst			mber)							ocation of Death		inty of Death		
Berlin Nurs					. Willad	ler 1 Ye	1	erli Under2		1		cceste		
5. Social Security Number 071–26–9804		ex □M 2ŽF	7. Age (In yrs 88	r. last birthda Yrs.	Month			lours	Min.	8. Date of Birt (Month, De 5-5-191	y. Year)	9. Birth Cou N	place (S intry) Y	itate or Foreig
Usual Residence of Decede  10a. State 10b. Co			10c, C	ity, Town or	Location								10d. Insi	ide City Limit
														Yes 2□N
	ceste	Г	00	ean C	-						10 011	4117 0	2241	
10e. Street and Number		. 40				ip Code 1842					USA	of What Cou	intry?	
217 26th S	t. Ap								- 14					
11. Marital Status  1 □ Never Married 2 □  3 ☒ Widowed 4 □ Divide		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 No	U,S. 13	3. Was Dec If Yes, sp 1 Yes			nic Origi lexican, pecify:	n? (Sp Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White scify: Wh		in,
15. Dec (Specify only I	edent's Ed	ucation		16a. Dec	cedent's Us	uel Occ	cupation	)	of work	ina	16b. Kind o	f Business/Ir	ndustry	
Elementary/Secondary (0		College (	1-4or 5+)	life	. DO NOT	use ret	rired)	y most t	- WUTK	9				The
8				Co	ook						State	Inst	itut	ion
17. Father's Name (First, Mi							18.	Mother'	s Nam	e (First, Middle,	Maiden Sun	neme)		
John Marino							C	011e	tta	(maide	n unki	nown)	Mari	.no
19a. Informant's Name/Rele	etionship (7	ype, Print)		19b. Me	iling Addre	ss (Stre	eet and i	Number	or Rui	al Route Number	er, City or To	wn, Stete, Zi	p Code)	
Patricia A.	Powe	rs, Da	ighter	217	26th	St.	Ap	t.#3	, 0	cean Ci	ty, Mo	1. 218	42	
20a. Method of Disposition			20b.	Place of Dis	position (N	lame of	n/a cal			Date	20c. Locati	on - City or T	own, Sta	ite
1 ◯ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State	. Pet					i	2-10	Haver	etrau	Nov	York
21. Signature of Funeral Se			7		22. Name					2-10	HUN CA	Jelaw,	AT C Y	TOTA
23a. Pert1. Enter the diseashock, or heert failure.  Immediate Cause (Final disease or condition resulting in death)		. Ac	,									1	Onset	al Between and Death
Sequentially list conditions, If eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last		b	Due to (	or as a cons	equence of	1t	105	d-	er	pret bisers			zer ye	יחצ
Death Other deatherston	- 4141				- 4- 4 1			D		not pid			h. 4h	ruse of death
Part II. Other algnificant con		,						Pan I.						4 Ki Unknov
ncole	Des	po les	7000	the	ml	201	15				Yss 2□ N	10 3 PH	Donoty	4 ALI OTIKITO
6 ree	+1	'hu	IN p1	17AD	tel						an autopsy med?	8	vailable	opsy findings prior to on of cause
										101	res 2 N	0 1	Yes	21X No
25. Was case referred to me	edical						26.	Place	of Deat	th (Check only o	ne)			
examiner? 1 ☐ Yes 2X No		Hospital:	Inpatient 2	ER/Outpat	ient 3 🗆 t	DOA	Other:	Nurs	sing Ho	ome 5 Resid	dence 6 🗆	Other (Spec	ify)	
	ending vestigation		of Injury (h, Day Year)	28b. Time Injun			njury et Work?	2 🗆 N		28d. Describe I	1175			
3 ☐ Suicide 6 ☐ C	ould not be etermined	250. PIBCE	of Injury - At h	nome, ferm,	street, fecto	ory, offic	CO			28f, Location (S City or Tox		umber or Ru	ral Route	Number,
4 ☐ Hornicide de 29a. Certifier 1 🛣 Cer	etermined tifying Phy dical Exam	puildi rsician: To the iner: On the b	ng, etc. (Speci	ify) owledge, de	ath occurre investigation	ed et the	e time, d	n, deeth	plece,	end due to the red at the time,	on, State) cause(s) and date end pla	I manner as	stated. to the ca	use:

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the Interaction forces as the bunal-transit completely filled in by the Interaction forces. Division of Vital Records, P.O. Box 68760,

29c. License number

29d. Date signed (Month, Day, Year)

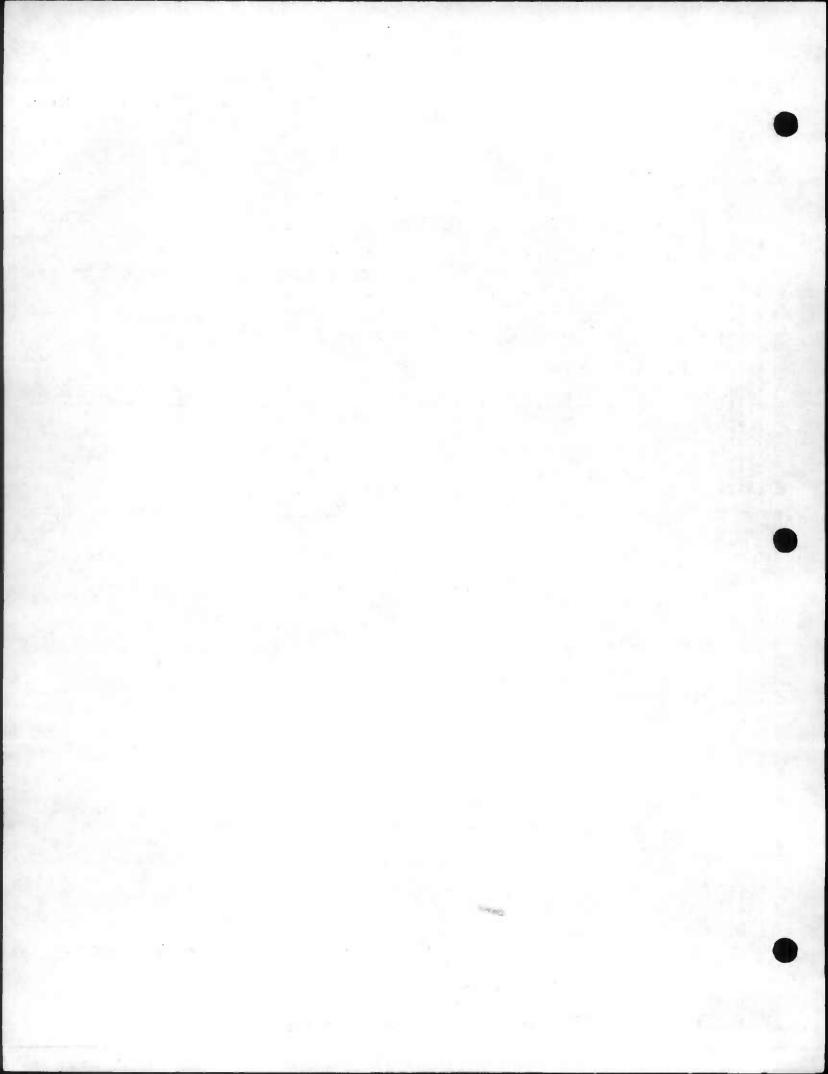
D02026

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811 410-641-4400

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature



## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:30 PM Carl Anton Kennel January 25, 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Residence- 5113 Main Street Grasonville | Hours | Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Fore Country) | Washinton DC If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days 64 579-44-5017 Director Usual Residence of Decedent the Merylend 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Queen Anne's Grasonville 1 Yes 2 No Director 10e. Street and Number 5113 Main Street 10f. Zip Code 10g. Citizen of What Country? with 21638 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 X Yes 2 □ No 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic svent, the Medical Everyna. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Service Man Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Josephine Wenzl Carl August Kennel 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Laura Webster/ Daughter 1673 Southeast Burning Rd. Port St. Lucie, FL. 34952 20b. Placa of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date MD. etery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Veterans Cemetery February 4,2000/Cheltenham, 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home Marcus location 106 Shamrock Rd. Chester, Fia 23a. Part 1. Effet the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. 106 Shamrock Rd. Chester, Maryland 21619 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final muitalet disease or condition resulting in death) **Examiner** Due to (or es a consequenca of): Examiner law requires that the death certificete be executed physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. edical Due to (or as a consequence of): 80 Physician/M use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signe. Records. À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Deen pege 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No Lo this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of After or Attending 1 Naturel
2 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours e Funeral [ Hospital edical 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

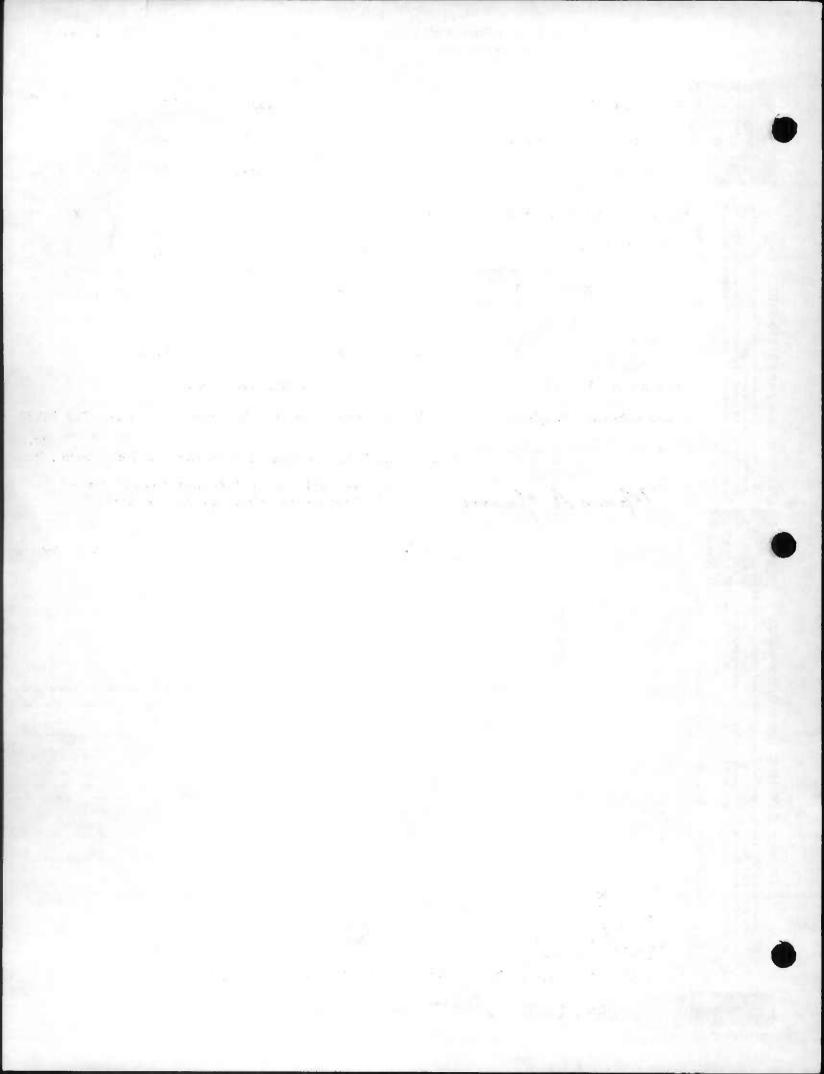
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie only To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title d certifier 20005759 30. Name and eddress of person who completed guse of deeth (Item 23a) (Type, Print)
Dr. Libby 204 Medicaal Center Rd. Grasonville, Maryland 21638 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State

bouls

**DHMH 16 Rev 6/95** 

Registrar

JAN 3 1 2000



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Jan 29 Dey Hugh Kilrov 2000 Joseph 05:35am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cumberland Nursing Center Cumberland Allegany 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Dete of Birth OCT 23, 1909 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 F 214-05-6054 90 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show 10d. Inside City Limits Director 1 Tyres 2 □ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 413 Maryland Avenue 21502 USA Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Apped Forces? 1 Byes 2 □ No if Yes, Give Yeer or Dates; WWII Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: white the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Heelth and Mental Hygiena. ant: If item 27 Is marked other then ' ury or other treumatic event, Ins Ma Elementery/Secondary (0-12) College (1-4or 5+) Bartender Restaurant Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Martin Kilrov Frances (Kelly) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Route 2 Box 526; Ridgeley, WV 26753 19a. Informent's Name/Reletionship (Type, Print) Suzanne Ujcic 202 daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Vurial 2 Cremetion 3 Remove from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Rocky Gap Veterans Cem2/01/ Flintstone, MD 22. Scarpeling For Tuneral Home P.A. 21. Signeture of Funeral Service Licenses Cumberland, Maryland 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only the cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel 10 aan diseese or condition resulting in deeth) neumona Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical use as the Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by à page 2 should be Completed 24b. Were autopsy findings evalleble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? peen Aftar this certificata has 1 Yes 1 Yes 2 No Attending Physician: Be 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA al or Attending Physics after death.

Il Director: After this ed in by the funeral di 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D compietely filled i Medical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signeture end tiple of certifier .29c. License number 29d. Date signed (Month, Day, Yeer) 10 Jan 29, 2000 1 33280 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Mis Gupta M.D. 625 Kent Avenue Cumberland MD 21502 Sunil K. EB 0 2 2000 2. Registrer's Signeture State Registrar

DHMH 16 Ray 6/95

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav WALTER GALEN KEPHART JR. January 31 2000 9:45 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Sacred Heart Hospital Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) 1**∑**M 2□ F Months Days Hours Yrs. 703-07-9256 Nov. 3, 1922 West Virginia Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Rt. 6, Box 6284 26726 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carman Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter George Kephart Mary Georgianna McGee 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter George Kephart/son Rt. 5, Box 34 Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 5 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, WV 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home with duan 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Finat disaasa or condition resulting in death) 647 LICHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 5MPHYSEMA 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy RENT AMUNE

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

**Director** 

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Nerne 23a or Examiner must be

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permit. Pages 1 and 2 should be filed within: Department of Health and Mental hygiene. Important: If Item 27 is marked other than \*1 any injury or other traumatic avant, the Mental Industrial Control of the Mental Industrial Contro

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Box 68760.

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Division of Vital

Physician/Medical p Completed Be To

sician and burial-transit attending physician certificata be the 88 signed by 8 peed certificate To the Hospital or Attending Physiolen: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, Certification:

edical WI 12

Registrar

CHUSTINE 31. Date filed (Month, Day, Year) State FEB 0 8 2000

25. Was case referred to medicat axaminar?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2☐ No 27. Menner of Death

Neturet 2 Accident

3 Suicide

29a. Certifier

4 Homlcide

VEW15

28a. Dete of Injury (Month, Day Year)

MD

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

224 WASHINGTON ST CUMBERLAND

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Morth, Day, Year) 2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 ☐ Yes 2 No

1 ☐ Yas > No

28d. Describe how injury occurred

26. Placa of Death (Check only one)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

eted cause of death (Item 23a) (Type, Print) 30. Name and address of person will

32. Registrar's Signature

DHMH 16 Rav 6/95

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Emory F. Kitzmiller llam January 26 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 331 Fairview St. Luke Allegany If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Months Days 1 M 2 F Yrs 216-05-9566 93 Feb. 22 1906 West Virginia Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Allegany Luke 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Fairview St. 21540 United States 12. Was Decedent Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian Black, Whita, atc. 1 Nevar Marriad 2 Married Yas 2 No 1 ☐ Yes 2 □ No Specify: Specify: White 3 NWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Paper finisher Papermaking Unknown 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surnama) David Kitzmiller Mary Hawk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Wilson Dau. 222 Miller St. Westernport, Md. 21562 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 1-29-00 Westernport, Md. 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Boal Funeral Home 111 Church St. Westernport, Md. Ze aepil Approximete Intarval Between Onset and Death 23a. Part1. Enter the disaesa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each tine. Immediata Causa (Final disease or condition resulting in death) Dua to (or as a consequence of): with vev Due to (or es a consequence of): Due to (or as a consequence of): well 0 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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Box 68760.

P.O.

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Division of Vital

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**Physician** 

/Medical

Examiner

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**Funeral** 

**Director** 

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altimore, Maryland 21215-0020

must be notified at

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Examiner Physician/Medicai þ Completed Be To **Medical Certification:** Director: J To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaase or injury that Initiated avants resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 45 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier (Check only one)

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State Registrar

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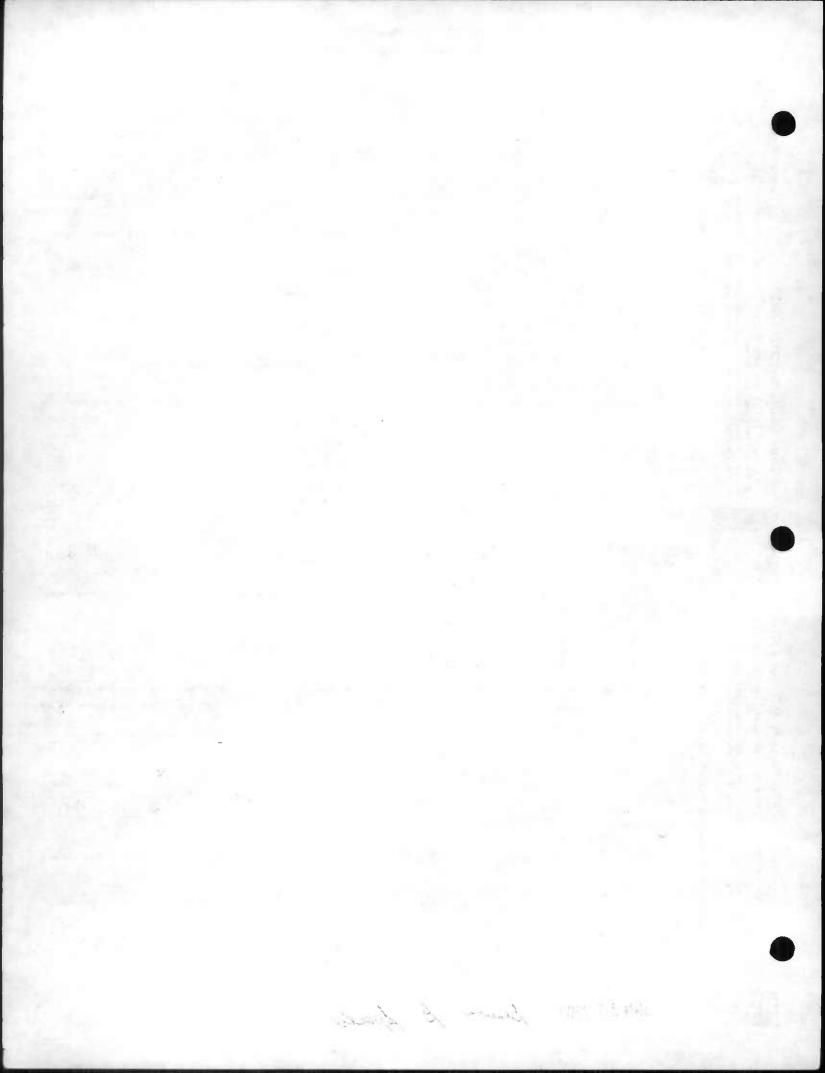
29c. License number 16515 29d. Date signed (Month, Day, Year)

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

D , Mineral & Newton Sts. Keyser, WV. 26726 MD Rabie Zalzal

31. Data filed (Month, Dey, Year) JAN 2 7 2000

29b. Signature apo titta of certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 9:00 p.m. February 6, 2000 Alton Leroy Lingrell 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
April 19, 1906 Pennsylvania Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours 1KIM 2 F Vrs 216-44-9926 93 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20877 301 Russell Avenue U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 Divorced White Yeer or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Department of Elementary/Secondary (0-12) College (1-4or 5+) Federal Meat Inspector Agriculture 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Lizzie F. Willier Judson B. Lingrell 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26200 Rudale Drive, Clarksburg, Maryland 20871 David A. Lingrell - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda Methodist Cemetery 2/10/00 Damascus, Maryland 4 Dona on 5 Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 20872-0117 Approximate Interval Between Onset and Deeth Immediate Cause (Final diseese or condition resulting In deeth) nneumonia Due to (or as a consequence of) ementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

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Baltimore, Maryland 21215-0020

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Pages 1 and 2 should be ment of Health and Menta tant: If Item 27 is marked jury or other traumetic ev

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physician and s the burial-transit attending pl signed by the a certificate has t lirector, page 2 s Physician: This s Attending death. • Euners efter death. • Funeral Director: A letely filled in by the fu

Division of Vital Records, P.O. Box 68760

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To the Hosp within 24 hor To the Fune completely fi

25. Was case referred to medicel examiner? 1 Yes 2 No 27. Mennal of Death

5 Pending investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 4 Homleide

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as steted.

29b. Signeture and title of certifier

29c. License number

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner steted.

1 ☐ Yes 2 ☐ No

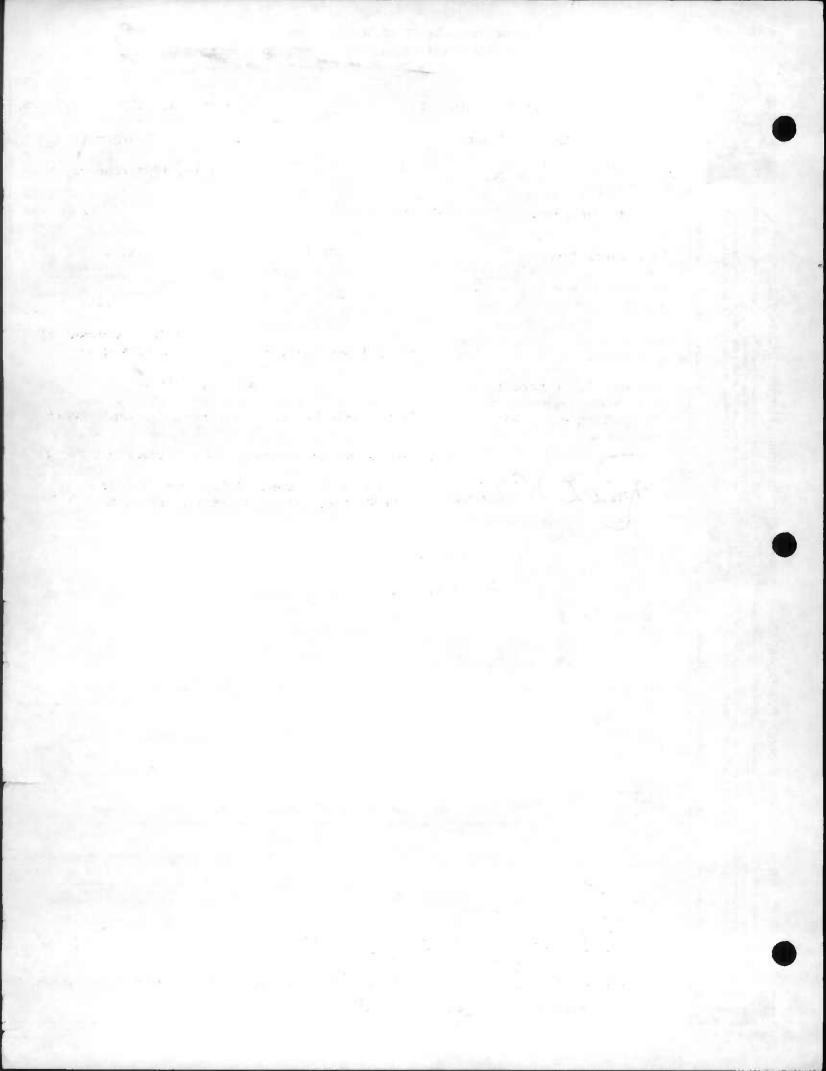
29d. Date signed (Month, Day, Year) 00

30. Neme and address of person who or deeth ((tem 23e) (Type, Print) ever

MO#4 Executive Park Court, Germantown, Md

28d. Describe how injury occurred

State Registrar 31. Date filed (Month, Day, Year) 32. Registrer's Signeture 9 2000



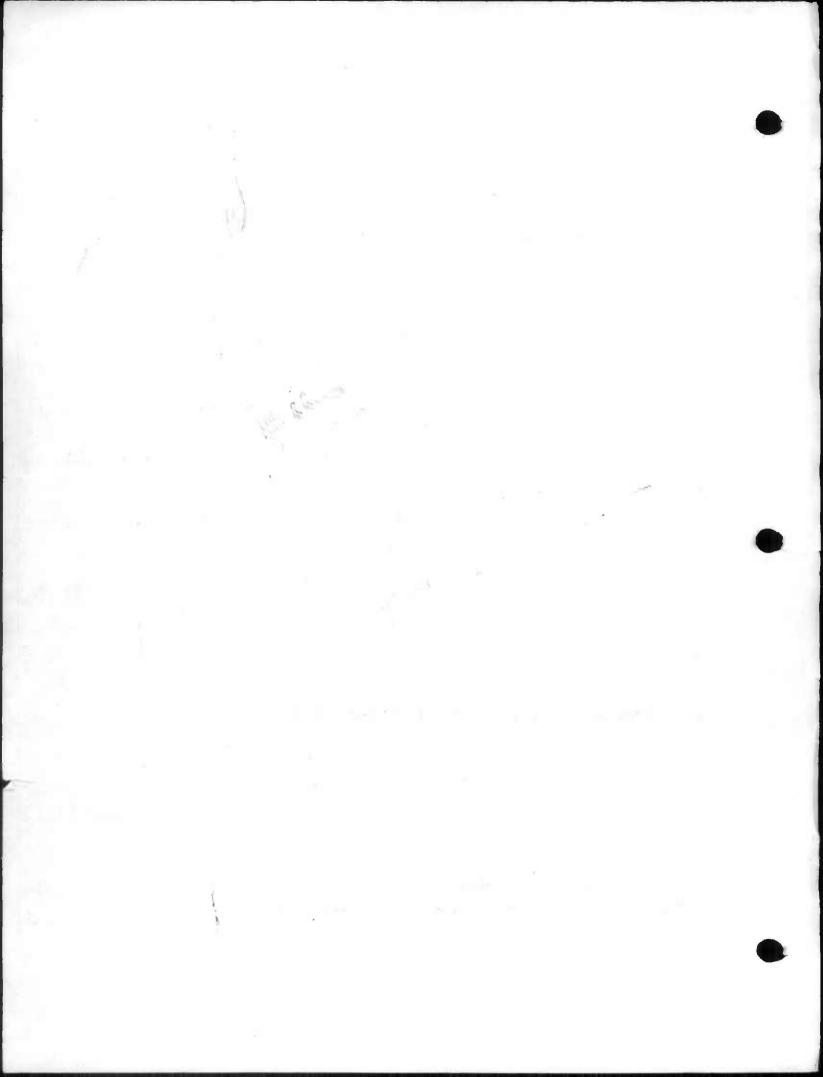
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any first death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

_	HEGISTHAN				CENTIF	ICALE	- OF	DEA	П	HEG. NO.			
	1. DECEDENT'S NAME (First	Middle, Last)	·			_				2. DATE OF DEATH			3. TIME OF DEATH
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	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.	. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	-, -		IPLACE (State or Foreign
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B	a Contractin	Investigation	200 BLACE O	F INJURY — A	hama fam				] 110				
		Could not be determined	building,	etc. (Specify)	t nome, sem,	street, ract	ory, ome	•		261. LOCATION (Street a City or Town, State)	ind Numbe	er or Rural F	loute Number,
ETED													
7	29e. CERTIFIER 1 CERT	TEYINO PHYSIC	CIAN: To the best of	my knowledge.	, desth occurr	ed at the t	lme, date	end place.	, end due	to the ceuse(s) end men	ner es st	sted.	
COMPL										time, date end place, en			) end manner es stated.
	29b. SIGNATURE AND BILL												
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2	20 NAME IND A	HU	C. /V4					03.	3700		1	ebrum	42,2000
	30. NAME AND ADDRESS OF												1
	Ted E. Howe			Artiz	zan St	. W	illi	amspo	ort,	MD 21795			
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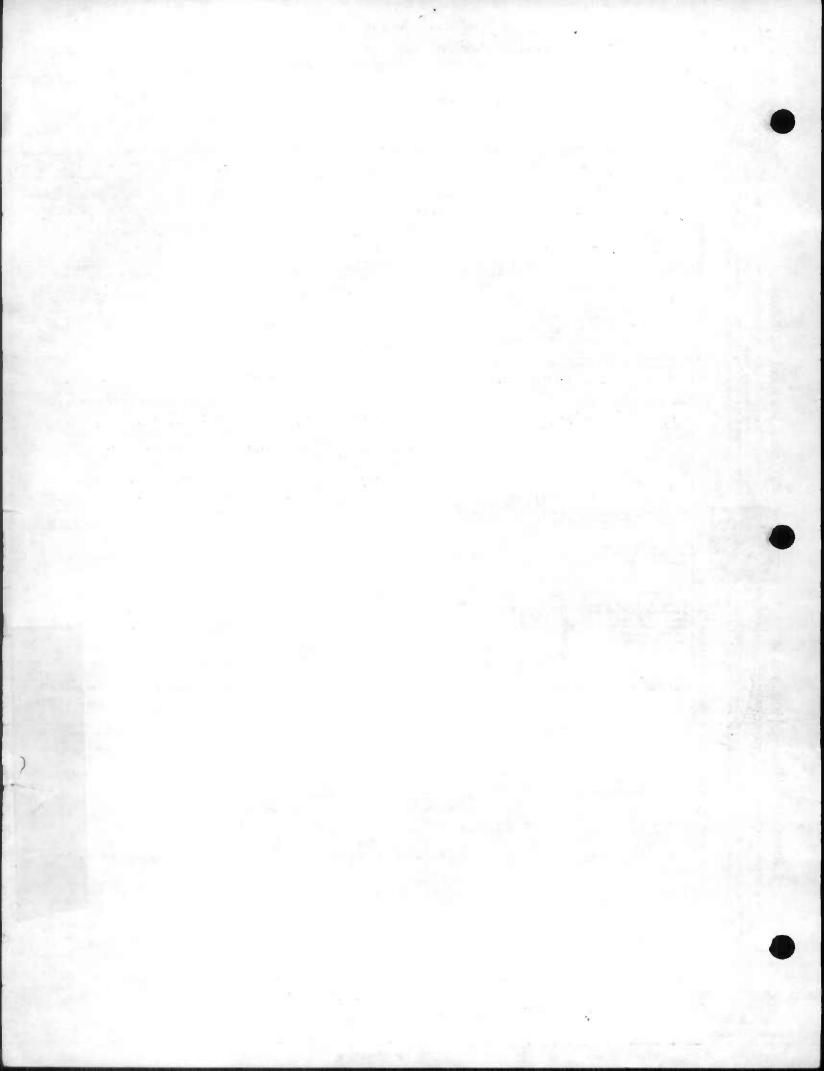
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-1033-047 Ronald Leonard AMEND ITEM: #26 PER State of Maryland Department of Health and Mental Hygiene

JVW AMEND ITEMS: #23 PART I, 27, 28A-F PER Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day 20, Year February 20, 2000 **Physician** Ronald J. Leonard, Jr. 11:30P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Ocean City 413 Eagle Drive Apartment 101 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec . 13, 1968 5. Social Security Number 9. Birthplace (State or Foreign Country) Mary Land 6. Sex 7. Age (In yrs. last birthday) Funeral 1 2 F 31 Yrs. Director 216-86-6815 the Meryland 10s. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director Worcester Maryland Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be or 10176 Winchester Lane 21811 USA permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mentai Hygiene. Important: If Item 27 is marked other than "natural", or frams 23a ents Injury or other traumatic event, the Hedical Examine measure. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes ZYNO
If Yes, Give
Year or Dates: 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald J. Leonard, Sr. Patricia Wright 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Arden Leonard/Grandfather 1130 Jansen Ave. Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurial 2 Cremation 3 Removel from State Sterling Cemetery 2/25/2000 Sterling, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon hill, Md. 20745 ales used the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23d. Part. Enter the disease, or complications that spock, or heart failure. List only one cause on Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical NARCOTIC INTOXICATION Examiner Due to (or es a consequence of): Examine certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): physician at the buriel 68760 Physician/Medical Due to for as a consequence of 8 Box 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 4 signed by the 1 Yes 2 No 3 Probably 4 Driknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Physician: 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 | Nursing Home 3 | Nursing Home 5 | Nursing Home 1∏Yes 2□ No 70 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: P Division Hospital or Attanding I 24 hours after death. After FOUND 30 5 Pending 1 Natural FOUND: FOUND: M 10 1 Yes 2 No UNKNOWN investigation 2 Accident Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Bural Route Number, City or Town, State) 413EAGLE DR. APT. 4 ☐ Homicide RESIDENCE To the Hospital of within 24 hours at To the Funeral Completely filled 101 OCEAN CITY, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 21,2000 O.C.M.E. 30, Name and address of person who comp ed cause of death (Item 23a) (Type, Print) 1DRY Davos Will Penn Street, Baltimore, Maryland 21201 32. Registral's Signature 31. Date filed (Month, Day, Year) 25 Registrar Darks DHMH 16 Rev 6/95

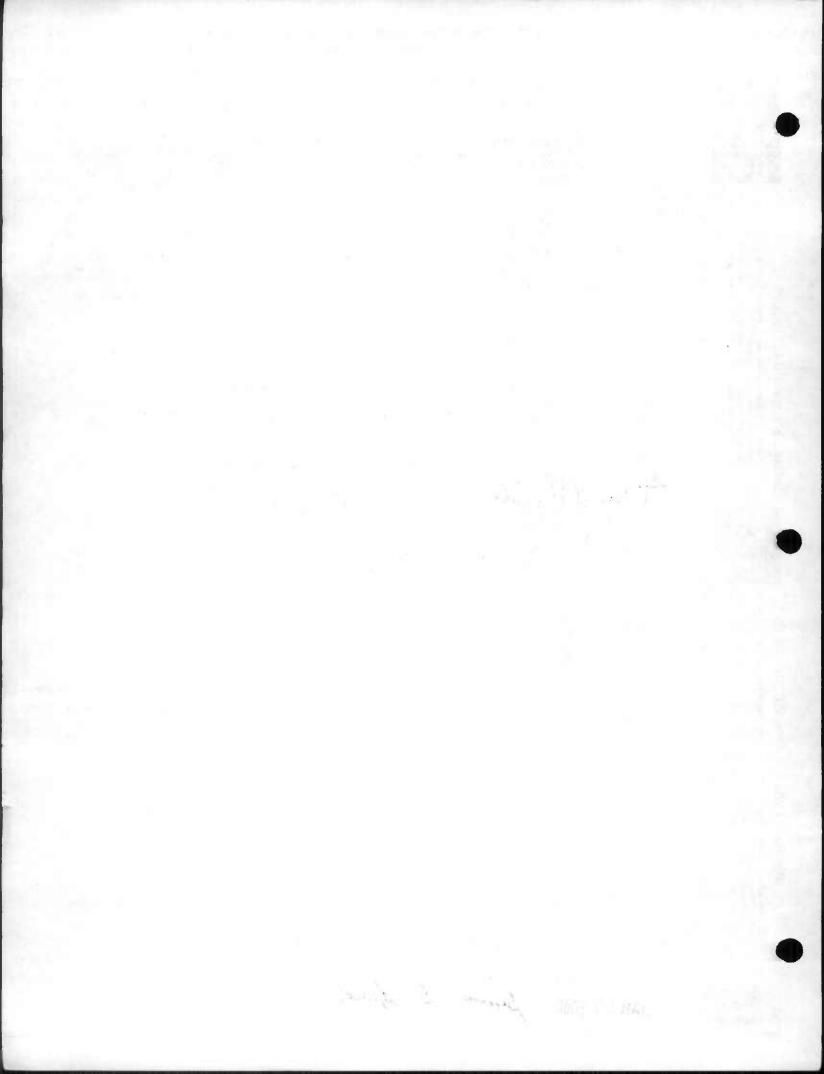
**ORIGINAL** 



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Death **Physician** Month JANUARY 26 2000 7:10 PM RAYMOND GARDNER LINN /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DEVLIN MANOR NURSING HOME CUMBERLAND ALLEGANY Hours Min. 8. Dete of Birth (Month, Day, MARCH 6 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Days MARY LAND Yrs. 99 Director 217-10-5091 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show items 23s or 28s-f show MARYLAND ALLEGANY CUMBERLAND 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1106 MICHIGAN AVENUE 21502 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. traumatic event, the Medical Examiner Pages 1 end 2 should be liled within 72 hours after or and or dreath end Mental Hydjene.
Int: If item 27 is marked other than "natural", or ites into or other traumatic event, its Mental Experient into or other traumatic event, its Mental Experient. 1 ☐ Yes 2 💆 No if Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 B&O RAILROAD MACHINIST 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE WASHINGTON LINN CORA LOUISE SMITH 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) NIECE 2003 BEDFORD ROAD CUMBERLAND MARYLAND MARY KATHLEEN HAMILTON 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, Stete Date Burial 2 Cremetion 3 Removel from State Department of important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) DAVIS MEMORIAL CEMETERY JAN 29 2000 CUMBERLAND MD. 21. Signature of Funerel Service Li 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Pent 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (of as e consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed for use as the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by i 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? certificete 1 Yes 2 JNO 1 ☐ Yes 2 ☐ No director, Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28e. Date of Injury (Month. Day Year) 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 X Waturel 5 Pending 1 Tyes 2 No ours efter death. eral Director: A filled in by the fi investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral D. completely filled Hospital 24 hours e 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated. Medical Exeminer: On the besis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of derti 29c. License number 29d. Date signed (Month, Day, Year) D 33280 JANUARY 27, 2000 30. Name and eddress of person with completed ceuse of death (Item 23e) (Type, Print) nus DR SUNIL K. GUPTA 625 KENT AVE CUMBERLAND MARYLAND 31. Date filed (Month, Day, JAN 27 State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

06283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 29, 2000 JAMES RALPH LITTEN 16:08 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 110 M 20 F 78 Director 232-26-2356 Aug. 7, 1921 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 ☐ Yes 2 ☑ No Director 28a-1 Mineral Keyser 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 35 Southern Drive 26726 Funeral USA 12. Was Decedent Ever in U,S.
Armed Forces?

1 [X] Yes 2 [ No
If Yes, Give
Year or Detes: WW II 14. Race - American Indian, 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.
Int. If them 27 is marked other than "natural", or he 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard Ballistics Laboratory altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 Gilbert Russell Litten Nannie Carol Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a If them 27 is or other tra Karen S. Litten/Daughter Rt. 6, Box 6357 Keyser, WV 26726 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stele Feb 2000 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) Keyser, WV Potomac Memorial Gardens 21. Signature of Funeral Service License 22 Name and Address of Fecility Smith Funeral Home Ireleu 85 S. Main Street Keyser, WV 26726 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Setween Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Congestive Heart Failure vear Due to (or as a consequence of): Examiner Cardiomyopathy 1 year burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequence of) Box 68760. Physician/Medical the Due to (or es e consequence of): for usa as signed by the at d be detached for 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 25(No 3 Probably 4 Unknown Diabetes Mellitus, hypertension, diffuse 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy arteriosclerosis page 2 a this certificate 1 ☐ Yes >Q No 1 ☐ Yes 2 ☐ No of Vital funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 154 apatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) After Division 5 Pending investigation 1 Netural 2 Accident Attanding 1 Tyes 2 No To the Hospital or Attandition 24 hours after death.

To the Funeral Director: A completely illied in by the fo death. 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the edicai (Check only one) ner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated 29b. Signeture and title of cortilies 29c. License number 29d. Date signed (Month, Day, Year) January 3 2000 w D31875 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Dr. Welik 902 Seten Drive, suite 308, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 0 8 2000 Registrar

DHMH 16 Ray 6/95

232-26-2356

Litten

FEB 8 8 2000 James & James &

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Mary Gertrude Lease February 3, 2000 8:45 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Memorial Hospital Cumberland If Under 1 Year 6. Date of Birth (Month, Day, Year) Dec 27, If Under 24 Hrs. Hours Min. Birthplece (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 L Yrs. 87 214-07-3726 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County ahow must be notified at Funeral Director 1 ☐ Yes 2 ☐ No 288-1 MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 220 Somerville Avenue 21502 USA Нета 23а Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?\_\_ 14. Race - American Indien, 11. Maritel Status Black, White, etc. 1 Yes 2 16 If Yes, Give Year or Dates: 1 Never Married 2 Merried 5 Specify: white 1□ Yes 2□No Specify. Completed by 3 Wildowed 4 Divorced "neturel" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Retired Employee JFK Institute 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ie marked of James F. Bergman Mary M (Steppe) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Department of Health at important: If Item 27 is eny injury or other treu phos. 17412 Hoskinson Road; Poolesville Ronald E. Lease MD 20837 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Macremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home2/04/ Cresaptown, MD e of Funeral Service Licer 22 Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Partf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 2 days Sepsis Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): physician Physician/Medical the Due to (or as a consequence of): ottending pl Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pneumonia, Diabetes Mellitus à 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? page 2 should Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Magner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this cardicate has a completely filled in by the funeral director, page 2. Division of Vital Mary Lease 2

The law requires that the death certificate be assecuted

Records, P.O. Box 68760,

214-07-3726

filed within 72 hours after death with the Maryland

21215-0020

Maryland

Baltimore,

Pages 1 and 2 should be

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature end title of cartifier

31. Date filed (Month, Day, Year)
FEB 0.4

Dr. Sunil K. Gupta Johnson Heights Medical Bldg. 625 Kent Ave. Suite 101 Cumberland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

D0033280

29d. Date signed (Month, Day, Year)

2000

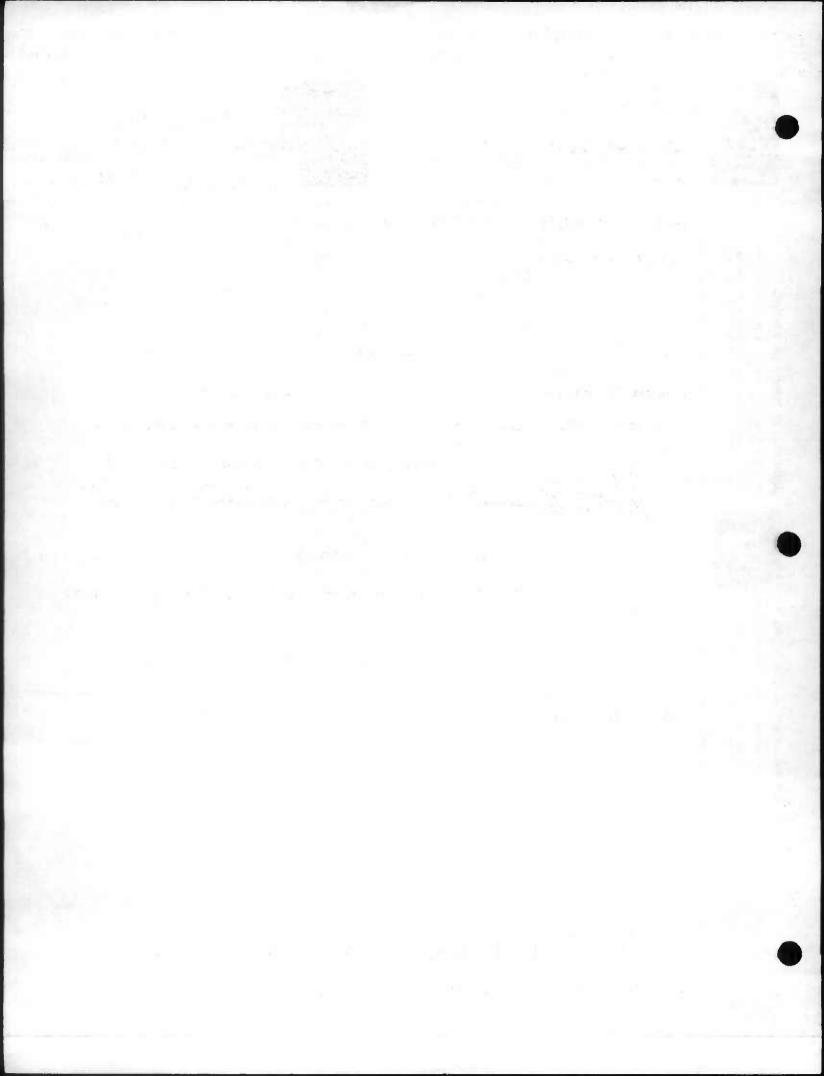
February3

**DHMH 16 Rev 6/95** 

FEB 0 4 2000 James 13 James

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici		1. Decedent's Neme (First, Middle, L	est)	STE I	Certifi			2. Dete of De			Time of Death
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/Medi Examir		4a. Fecility Neme (If not institution, ga	ve street and number)	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, or L	FEBRUAR ocation of Death	Y 11 2 4c. County	000	
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Funerai	Г	5. Social Security Number 6.	Sex 7. Age	e (In yrs. las		Inder 1 Yeer	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De			(Stete or Foreign
Director		579-56-5544	1□ M 2□ <b>X</b> F	55	Yrs.	Luis Boys	110010	MAY 24			gton, DO
and *		Usuel Residence of Decedent  10a. State 10b. County		10c City 7	Town or Location	1					
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28a-	Director	Maryland St Mary  10e. Street end Number	5	MeCI.		f. Zip Code	<u> </u>		10g. Citizen of V		21
with with	ā	29927 Burton Ro	n d			2065	-0			·	
Jeath Tre 2:	Funeral	11. Marital Status	12. Wes Decedent E	Ever in U.S.	13. Was [		Hispenic Origin? (Sp en, Mexican, Puerto	pecify Yes or No	- 14. Rac	a - American I	ndien,
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or itema 23a or 28a-f show umatic event, if a Medical Exam set must be notified.	by	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 N  If Yes, Give  Yeer or Detes:	ło		specify Cub	en, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, etc. Whi	te
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12 should be filed v h and Mental Hygie I is marked other t raumatic event, th	Be	17. Fether's Neme (First, Middle, Las	1)				18. Mother'e Nam	ne (First, Middle,	Meiden Sumen	ne)	
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12 sh h and r is m traun		19a. Informent's Neme/Reletionship					and Number or Ru				
s 1 end 2 should f Health and Mer tem 27 is marke other traumatic		Lucretia C. Cop  20e. Method of Disposition	sey (Daught	-	2/248 Coe of Disposition		Buckler :	La Mecha Date	20c. Location -		
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		4 Donetion 5 Other (Special Signature of Fungerel Service Lice		St M	fary's C		on of Engility	-14-00			
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		23a. Pert1 Enter the disease, or cor shock, or heert failure. List only	w	46 - 4 - 46			e Pls la				proximete
Physician /Medicai Examiner		immediate Ceuse (Finel disease or condition resulting in deeth)	e. Cardi							On	ervei Between set and Deeth
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year **Physician** Norma L. McAllister 30 2000 January 6:40am /Medical 4b. City, Town, or Location of Death 4a Fscility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Deys Yrs. 219-36-5810 86 Director Feb. 6,1913 Maryland Usual Residence of Decedent r 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 X Yas 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 and Mental Hygiene.

Interest of Heart and Mental Hygiene.

Interest of the marked orber than "natural", or florms 23a or :

ury or other traumatic event, the lend. Funeral 405 Snow Hill Road 20104 United States 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 5+ Teacher 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 0 Hatteras Reagan Ann Rebecca Stewart 19s. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul Redding / Grandson 24308 Flamingo Terrace, Gaithersburg, Md 20882 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematorium 2/1/00 Alexandria, Virginia 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Olin L. Molesworth P. A. Funeral Home 23a. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 26401 Ridge Road, Damascus, Maryland 20872 Approximate tntervat Between Onset and Death **Physician** tmmediete Cause (Finel disease or condition resulting in deeth) /Medical Acite Respirations )
Due to (or as a consequence of): minites Examiner lears The law requires that the deeth certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es e consequence of) P.O. Box 68760. physician Physician/Medical the Due to (or es a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown à ate hes been signed page 2 should be de Records, þ 24b. Were eutopsy tindings evailable prior to completion of cause of death? Completed 24e. Wes en autopsy parformed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: " within 24 hours after death." To the Funeral Director: After this certifica funeral director. 8 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signød (Month, Day, Year) 233357 m

State Registrar 00

31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

530

30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print)

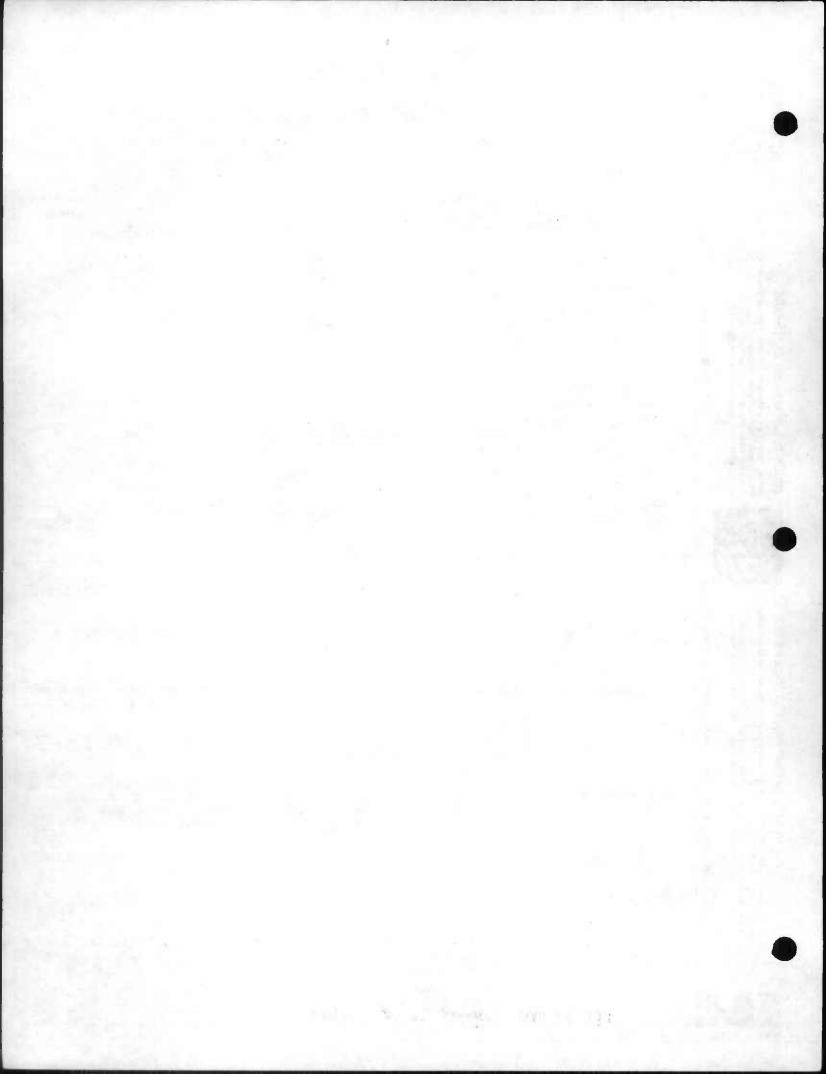
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Musher

32. Registrar's Signeture

200

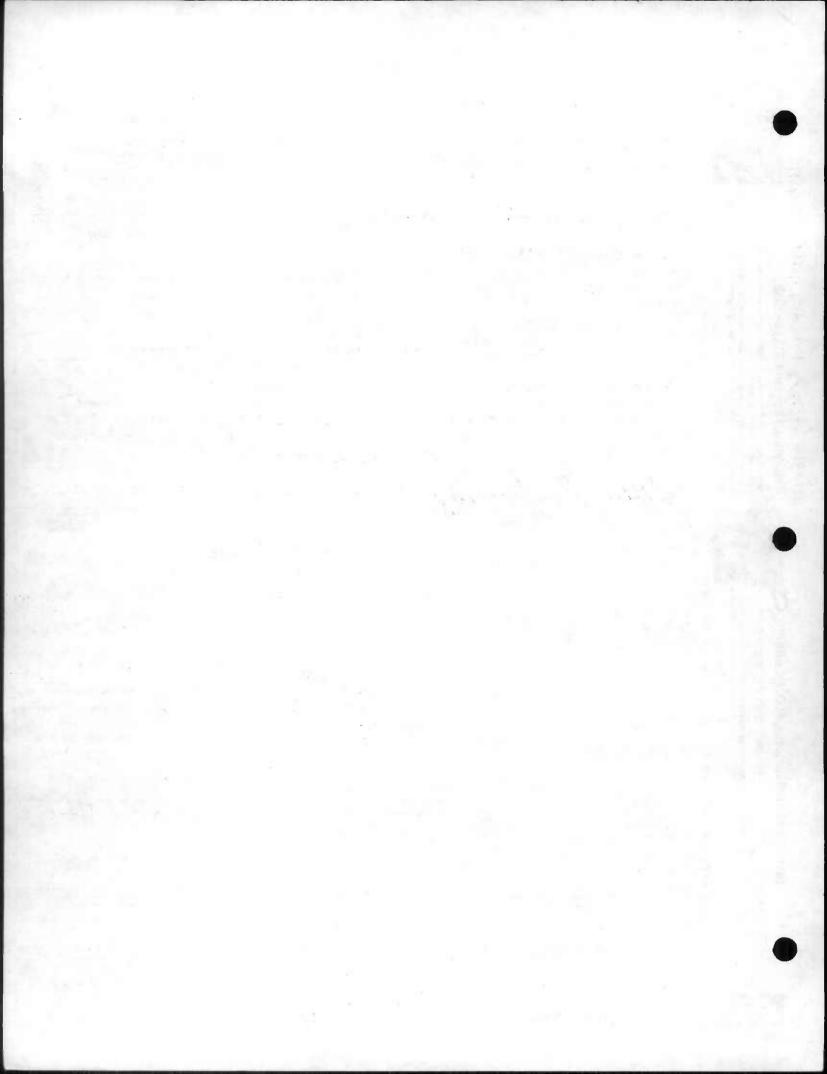
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# Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Discontinuity	1. Decedent's Name (First, Middle, Las	0				2. Date of De Month		Vaer	3. Time of Death	
Physician /Medical	LINDA I	OWE MORRIS				Feb.	7, Day 200	00	11:22 PM	
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or I	ocation of Deat	th 4c. County	y of Death		
	Gilchrest Cent	er- GBMC			Towson		Ba1ti			
Funeral	5. Social Security Number 6. Se	TM SELE	rs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	(Month, Di	rth ay, Year)		ace (Stete or Foreign	
rector	Usual Residence of Decedent	52 52	115.			8/14/	1947	Mary	land	
ž ==	10a. State 10b. County	10c. (	City, Town or Lo	cation				10	d. Inside City Limits	
- N	MD Balti	more	Phoen	ix					1□ Yes 2√√Vo	
be notified Director	10e. Street and Number		111001	10f. Zip Co	de		10g. Citizen of	What Count		
4 0	2244 Carroll	Mill Road			21131		USA			
Funeral	11. Marital Status	12. Was Decedent Ever in	U,S. 13.		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No		ce - America		
	1 ☐ Never Married <b>3</b> ☐ Married	Armed Forces?				o Rican, etc.)		ck, White, e	tc.	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 LI Yes -1243	No Specify:		Specif	lite		
e de	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	ient's Usual O	ccupation	kina	16b. Kind of B	usiness/Ind	ustry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			one during most of wor etired)					
		5#	Featu	re wr			Newspa			
Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nan			ne)		
To To		forris			Eleanor					
Iran	19e. Informant's Name/Relationship (T) Theodore F. She		1000		reet and Number or Ru					
ž	20a. Method of Disposition	_	. Placa of Dispo			Date Date	20c. Location			
	1 ☐ Burial 2 🛣 💢 emation 3 ☐ l	Removal from State	cemetery, crer	netory or other	plece)					
dury	4 Donation 5 Other (Specify,				rematory	2/9/00	reore	i, PA		
any i	21. Sgrange of Fugural Service Com	tail	11		ddress of Facility F.H.Inc	. 600	Main S	st.,	Delta, PA	
	Highly !	Journa	1					7314		
	shock, or heart leilure. List only of	ne cause on each line.	min. Do not ent	er the mode of	oying, such es cardiac	or respiretory a	irrest,		Approximate Interval Between Onset and Death	
ician dical	Immediate Cause (Final	0.	1.1.	1	moltis				0	
iner	disease or condition resulting in death)	guo			molfing	orme		- 1	8 month	
ě		Oue to	(or as a consec	juence of):						
burial-transit	Sequentially list conditions	b. Due to	(or as a consec	mence off.						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	50010	(0. 85 8 00.1500	do:100 017.						
s the bu	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						
	A STATE OF THE PARTY OF THE PAR							1		
be detached for use by Physician/M		d						1		
sici	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying caus	e given in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?	
detached detached						10	Yaa 2 No	3 Prob	ably 4 Unknown	
be del								1		
should should						24a. Wes	s an eutopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause	
as b								of c	leath?	
						10	Yes 2 No	10	Yes 2□ No	
Completed					26. Place of Dea	ith (Check only	one)	17 - 1	11	
B Sctor	25. Was case referred to medical examiner?		☐ ER/Outpatier			100	idence 6 Ott		Hospice	
his certific	examiner?	Hospital: 1 Inpatient 2	Loot W			28d. Describe how injury occurred				
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funeral director.	examiner? 1  Yes 2 No  27. Manner of Death 1 Netural 5 Pending	28a. Date of Injury	Injury home, farm, str	М	1 Yes 2 No	28f. Location	(Street end Num	ber or Rural	Route Number,	
funeral director,	examiner?  1 Yes 2 No  27. Manner of Death 1 Notural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At building, etc. (Spec	home, farm, str	M eet, factory, of	1 Yes 2 No	28f. Location City or To	wn, Stete)			
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for: After this certific the funeral director cation: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 No Netural 2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only and) 29b. Signalum and talls of certifier	28a. Date of Injury (Month, Dey Year)  28e. Plece of Injury - At building, etc. (Speniar: To the best of my kiner: On the basis of examine.	home, farm, str cify)	M eet, factory, of a cocurred at the restigation, in a 29c. Lin	1 Yes 2 No fice  ne time, date and place my opinion, death occur cense number	28f. Location City or To	cause(s) and m date and place,	anner as strand due to	ated. the cause(s)  Day, Year)	

DHMH 16 Rav 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5200 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, 2000 11:35 AM Alice. Morrison 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Dey, Year) Aug. 30, 1904 Michigan If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys Months Hours 1□M 2♥F 95 218-24-0667 Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21703 7061 Catapla Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marilal Stelus Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Hilliard Nora Walter 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 135 West Patrick Street, Frederick, Md. 21701 Mr. Herbert D. Morrison, son 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removel from Stete Smithsburg Crematory, Feb. 3, 2000 Smithsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility. Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Respiratory Failure days Due to (or as e consequence of): Pneumonia days Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Fractured Left Hip 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

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efter death.

24 hours Funeral

To the To the To the

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Certification: To

Medical

Attending Physician:

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The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

na 23a or 28a-f ahow must be notified at

Heme!

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natural.

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permit. Peges 1 and 2 abould be file Department of Health and Mental Hy Important: If Item 27 is married oth eny Injury or other traumatic event abots.

filed within 72 hours after

21215-0020

Baltimore, Maryland

Funeral Director

Completed by

Be

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Physician/Medical þ Completed

25. Was case referred to medical 1 Yes 2 No

6 Could not be determined

27. Menner of Death

1 Netural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 5 Pending investigation Jan 25,2000

Hospital

28b. Time of Injury 11:30a M 28e. Plece of Injury - At home, farm, streel, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2₺ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Patient fell getting from bed

28f. Location (Street and Number or Rural Route Number, City or Town, State) 400 West Seventh St Frederick, Maryland

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D35164

February 3, 2000

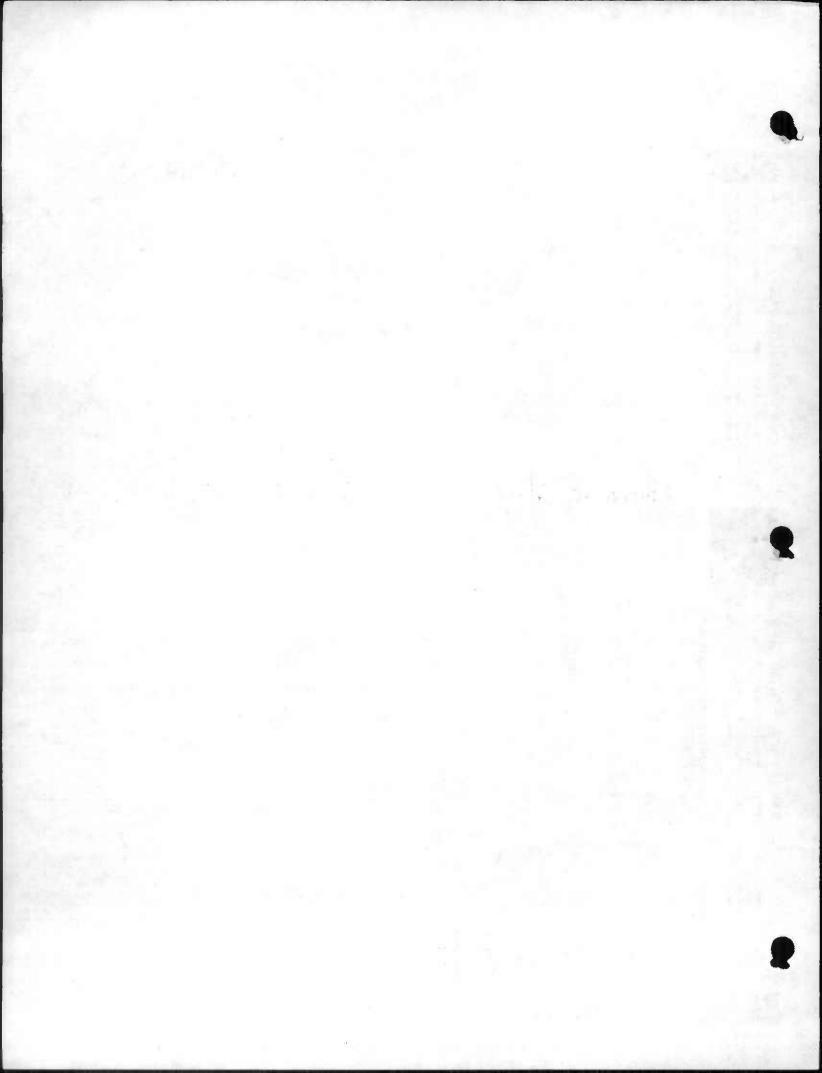
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 3 2000 >

M.D, Andrew Zarick, Jr, 1080 West Patrick Street, Frederick, Maryland 21703 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#26per doctor 2/9/2000 FCHD, KS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dolores Valeria Miller February 8, 2000 cation of Death 4c. County of Death 12:02 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6610 Mountainview Drive Frederick Frederick 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2KDF Months Director 6/29/1915 150-22-7460 Pennsylvania Usual Residence of Decede 10a State 10c City Town or Location 10b. County 10d. Inside City Limits r than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Burgess Hill Way, Apt #105 21702 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglens. other than "n College (1-4or 5+) Elementary/Secondary (0-12) 8 Seamstress Clothing Factory permit. Pages 1 and 2 should be file Department of Yeelth and Mertal Hy Important: If them 27 is marked othe eny injury or other treumetic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Orbus Agnes Peteritas 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. Swartwood, daughter 6610 Mountain View Dr., Frederick, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 2/12/ 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Mother (Specify) Entombment St. Mary's Mausoleum 2000 Wilkes-Barre, PA 21. Signature of Funeral Service Licensis 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 | 106 East Church Street, Free 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or healt feiture. List only one cause on each line. M00999 106 East Church Street, Frederick, 21701 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) he Sxaminer Examine the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician Box 68760 Physician/Medical Due to (or as a consequence of): 88 980 6 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? P.O. the signed by ti Atherosofertie Coldio Vasualar Disease 12 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy lindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) daughter's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Salo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred residence After t Division Hospital or Attending 5 Pending investigation Natural n 24 hours effer death.

Ne Funeral Director: Aftisistaly filled in by the fur-1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

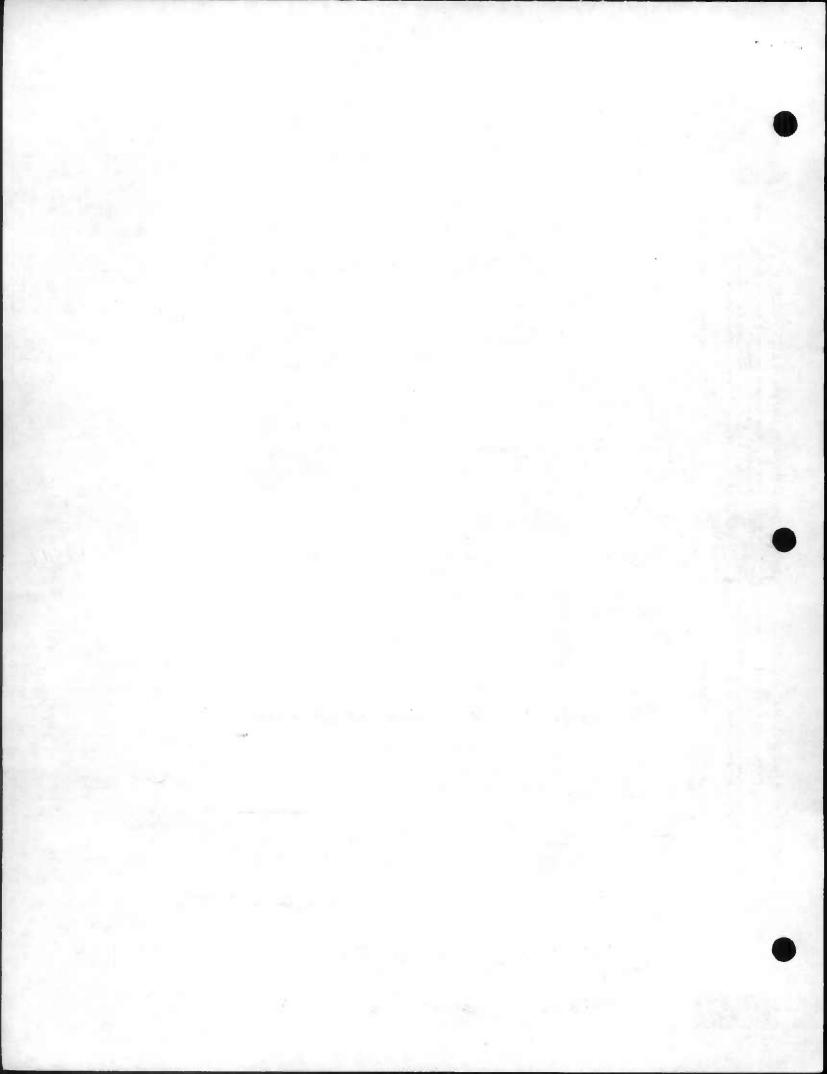
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the edical 29a. Certifier (Check only one) iner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. To the P within 2. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 16428

State Registrar Casper E.

31. Date filed (Month, Day 16

Cline III, M.D., 300 West Ninth Street, Frederick, Md. 21701

o of death (News 23a) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#7,2/1/00,FCHD,KS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** NANCY MERCER 31, JANUARY 2000 6:30 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COLLEGE VIEW NURSING HOME FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 2\ F 78Yrs. 218-24-9626 Nov 17, 1921 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pes 2□No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 301 Locust Street 21702 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Homemaker self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Milton E. Harris Smith Maude Lucas 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Mercer / daughter 301 Locust Street, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 3 4 ☐ Donation 5 ☐ Other (Specify) OO Leesburg, Virginia Union Memorial Cemetery nature of Funeral Servica Licansee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Tenter the mode of dying, such es cardiac or respiratory arrest, Alzheimes Immediate Cause (Final Disease disease or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Bladder wmon 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

**Physician** /Medical Examiner

The law requires that the death certificate be executed

certificata

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After

Box 68760.

P.O.

Records,

Division of Vitai Attending Physicien: **Funeral** 

Director

ahow.

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Menyland

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filed within 72 hours after

Hygiene.

other 1

permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If item 27 Is marked othe any injury or other traumatic event bace.

altimore, Maryland 21215-0020

Examiner

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attending physicien end for use as the burial-transit Redical ed by the a P S page 2 director funeral in 24 hours after death.

• Funerel Director: After etely filled in by \*\*\* Certification

1 Yes 2 No 7. Manner of Death

1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Year) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

21702

281. Location (Street and Number or Rural Route Number, City or Town, State) l Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

29b. Signeture and title of confi

29a. Certifier

(Check only one)

JULIO MEHOLA

29c. License number 0-31

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end meaner stated.

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PILLE

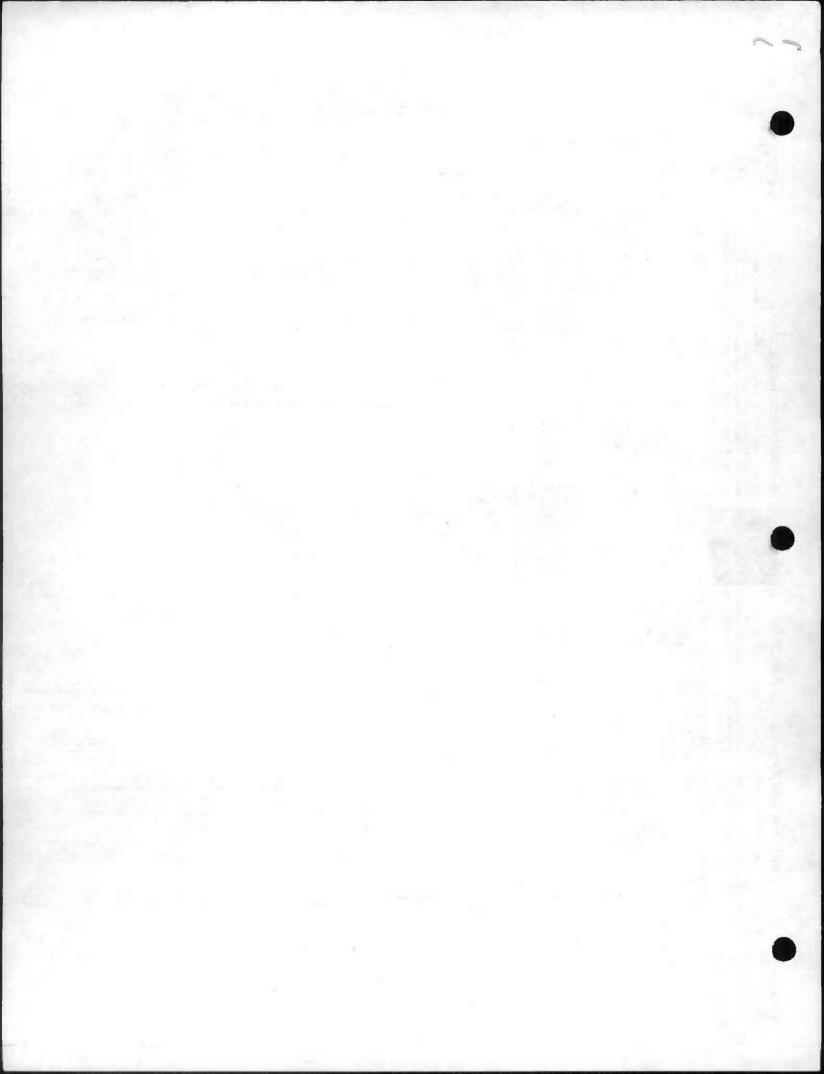
OPUSSUM TOWN 0 1 2000 Registrat's Signature

FRE DERILY

State Registrar

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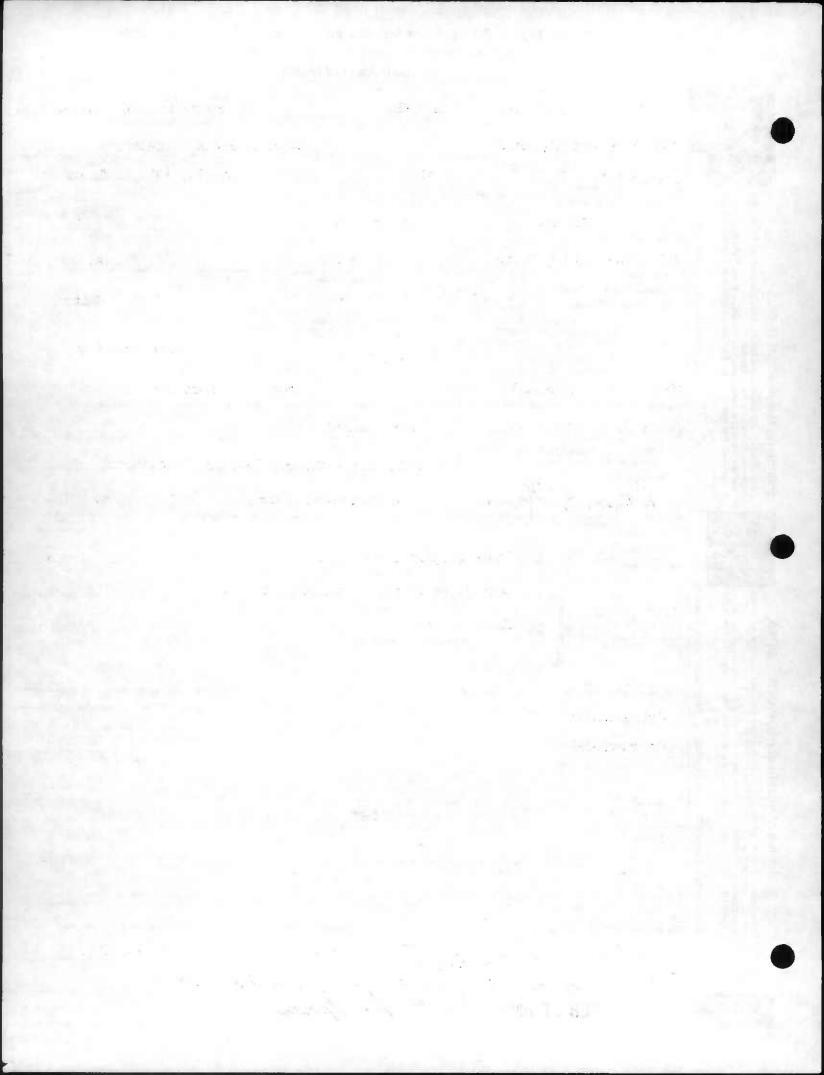
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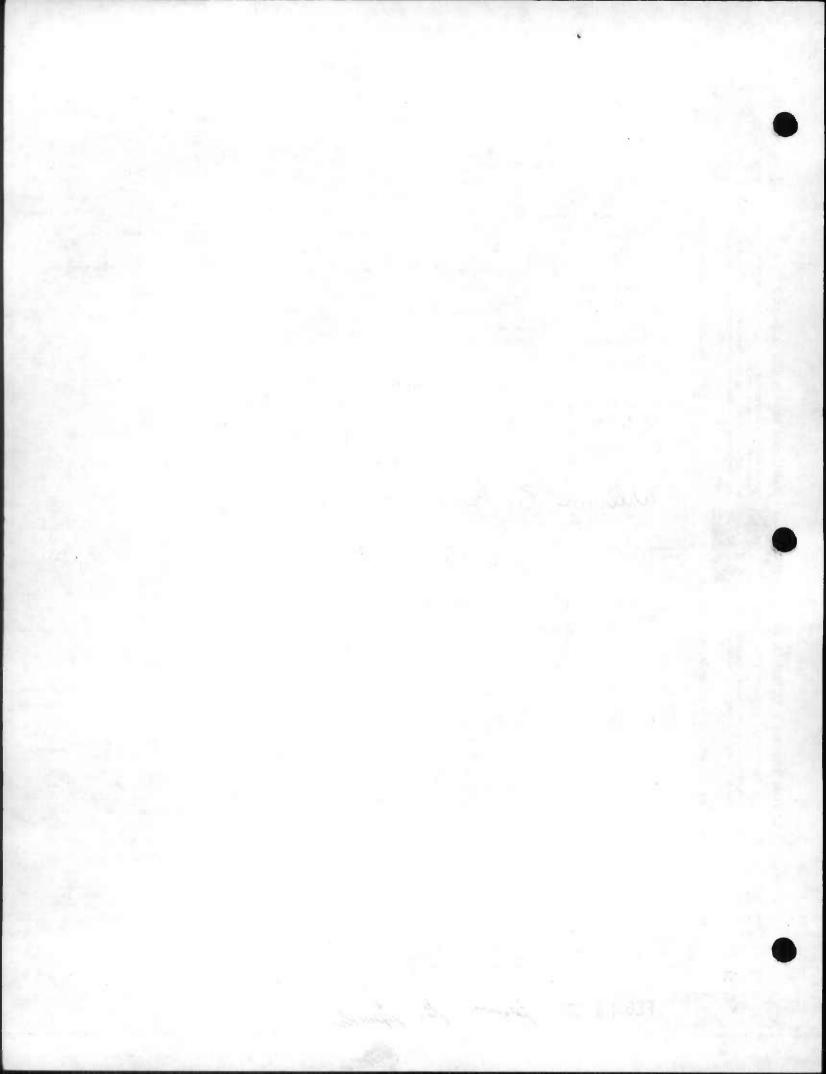
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth Dey Month **Physician MEDSKER** 11:30 a.m. PAULTNE February 14 2000 /Medical 4e Facility Name (If not institution, give street and number) 4h City Town or Location of Deeth 4c. County of Death Examiner 8077 Windward Key Drive Chesapeake Beach If Under 1 Yeer 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** Min 1 □ M 2 10 F Months Deys Hours Yrs. 81 June 15, 1918 Director Indiana 316-07-9081
Usual Residence of Decedent the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ? Is marked other than "natural", or ferms 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 8077 Windward Key Drive 20732 Funeral U.S.A.

14. Race - American Indian. death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mentel Hygiene.
Int: If Item 27 Is marked other than "natural", or ite iry or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: à White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Hair Dressing 12 Beautician 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be Harry Freeland Peterson Anna 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Larry R. Medsker / son same as #10 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or once. Valhalla Memory Gardens 2-19-00 Bloomington, IN 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses wos Rausch Funeral Home, P.A., Owings, MD 20736 Mam 7 23e. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Acute Respiratory Arrest minute Examiner Due to (or es e consequence of): Examiner Chronic Obstructive Pulmonary Disease 5 years the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760. Chronic Bronchitis 6 years Physician/Medical Due to (or es e consequence of): attending ph ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown signed t Osteoporosis Records, by 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Was en eutopsy performed? Completed Osteoarthritis i certificete hes b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director. 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) To Hospital: Other: 4 ☐ Nursing Home 52 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 24 hours after death.
Funerel Director: After ti Certification: 5 Pending Investigation After 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 Homicide .0 To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) 29a. Certifier Medical (Check only one) end manner stated. 29d. Date sloned (Month, Dev. Year) 29b. Signeture and tiple of certifier 29c. License number D 04060 Feb. 15, 2000 Heted carse of death (Non 23a) (Type, Print) 30. Name and address of person who 6 Robert F. Dyerthe) Thank Chase Md. 20815 5530 WISC. Ave, 2000 Registra's Signetura souls

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** BERTIE HOWARD MATTOON February 6 2000 12:20 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 F 212 10 4989 95 June 1, 1904 Director Owings, Maryland Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show The Medical Examiner must be notified at Maryland Anne Arundel Crofton 1 ☐ Yas 2 No Directo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify. p 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if Item 27 Is marked other that eny Injury or other traumatic event, that page. tie maker 8 garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Howard Ella Sherbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Diane H. Babcock, great-niece 1420 Wrighton Road, Lothian, 20711 MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) entombment Lorraine Mausoleum 2-8-00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The lew requires that the deeth certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Demenho Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en autopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Affer 1 ANatural or Attending 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Load #106 JUly 32. Registrar's Signature 1 0 2000 Registrar



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Day Honor Peath & County of Death TAMES 0 MCINTYRE 1648 13000 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death SALISBURY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1₩ M 2□ F Months Days 214-28-8520 67 December 10,1932 Maryland Usual Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Maryland Mardela Springs 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 8685 Riggin Road 21837 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, Whita, etc. 1 Xas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Army 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Natural Resources 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Straughn McIntyre Anna Bounds 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Lois E. McIntyre/Wife 8685 Riggin Rd., Mardela Springs, MD 21837 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Allen Cemetery 2/12/00 Allen, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Fecility Holloway Funeral Home Professional Association 21. Signeture of Funarel Service Liga 501 Snow Hill Rd., Salisbury, MD 21804 Keith 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceusa (Finai diseese or condition resulting in deeth) VENTRICULAR MINUTES Due to (or as a consequence of) JORG CORONALY MIERY Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initieled avants resulting in daeth) Last Dua to (or es e consequence of) CALDIDMY, PATH YEMS Due to (or as a consaquence of): CORONDAY DILFASE BELEVY -renas 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of daeth? 24e. Wes an eutopsy performed? 1 ☐ Yes E ☐ No 1 ☐ Yas 2 ☐ No 26. Piece of Deeth (Check only one) 1 Dinpatient 2 ER/Outpetient 3 DOA

**Physician** /Medical Examiner

Examiner

Physician/Medical

by

Completed

10

Medical Certification:

29b. Signature and title of a

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

Be

2

**Funeral** 

Director

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r than "natural", or items 23s or 28s-f shor the Medical Examiner must be notified at

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Department of Health a Important: If Item 27 is any Injury or other trac

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altimore, Maryland 21215-0020

The law requires that the death certificate be executed burial-transit and Records, P.O. Box 68760. attending physician the SB jo signed by the a peed paga 2 s certificate Division of Vital Be this After

To the Hospital or Attanding Physician: after death.

I Director: Aft
d in by the fur hours after within 24 hours aft To the Funeral Di completely filled in

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State Registrar

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case refarred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledga, deeth occurred et the time, date end plece, and due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, deeth occurred et tha time, date and place, and due to the ceuse(s) end mannar stated. 29a. Cartifier

29c. License number

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JAMES TRAD

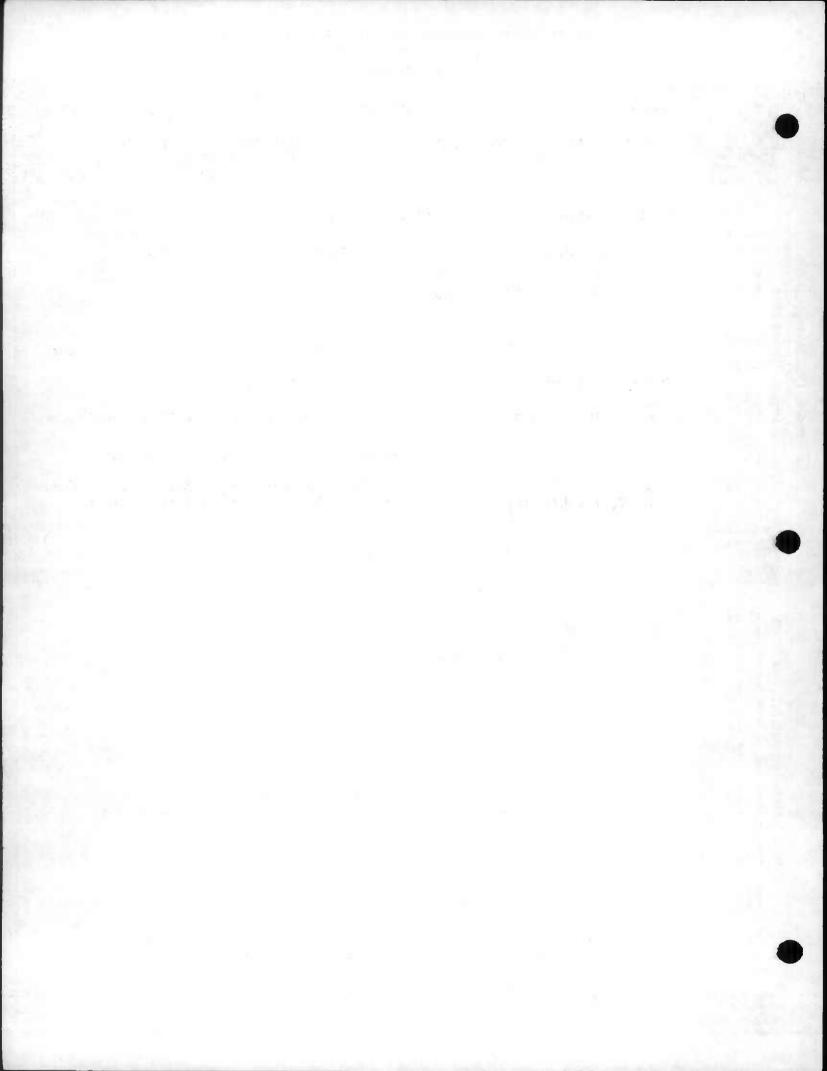
32. Registrar's Signature

30. Nama and address of parson who complated ceusa of death (Itam 23a) (Type, Print)

TODD

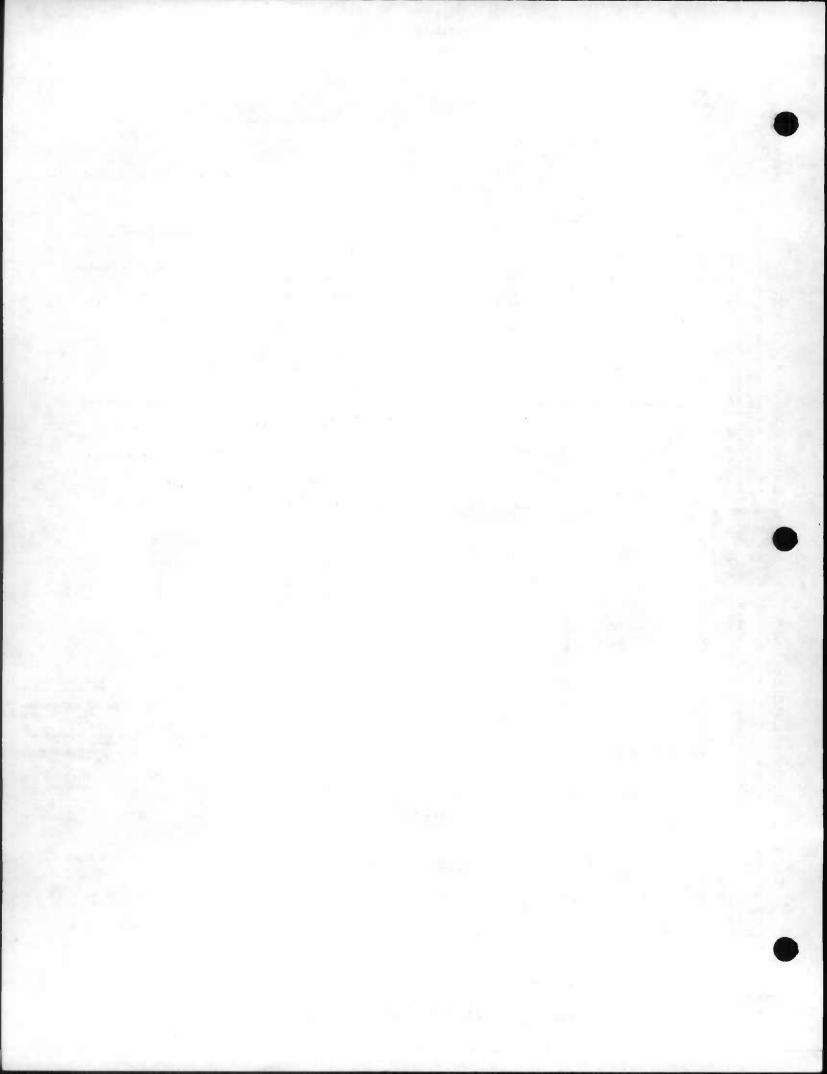
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State of Maryland / Department of Health and Mental Hygiene 00 06294

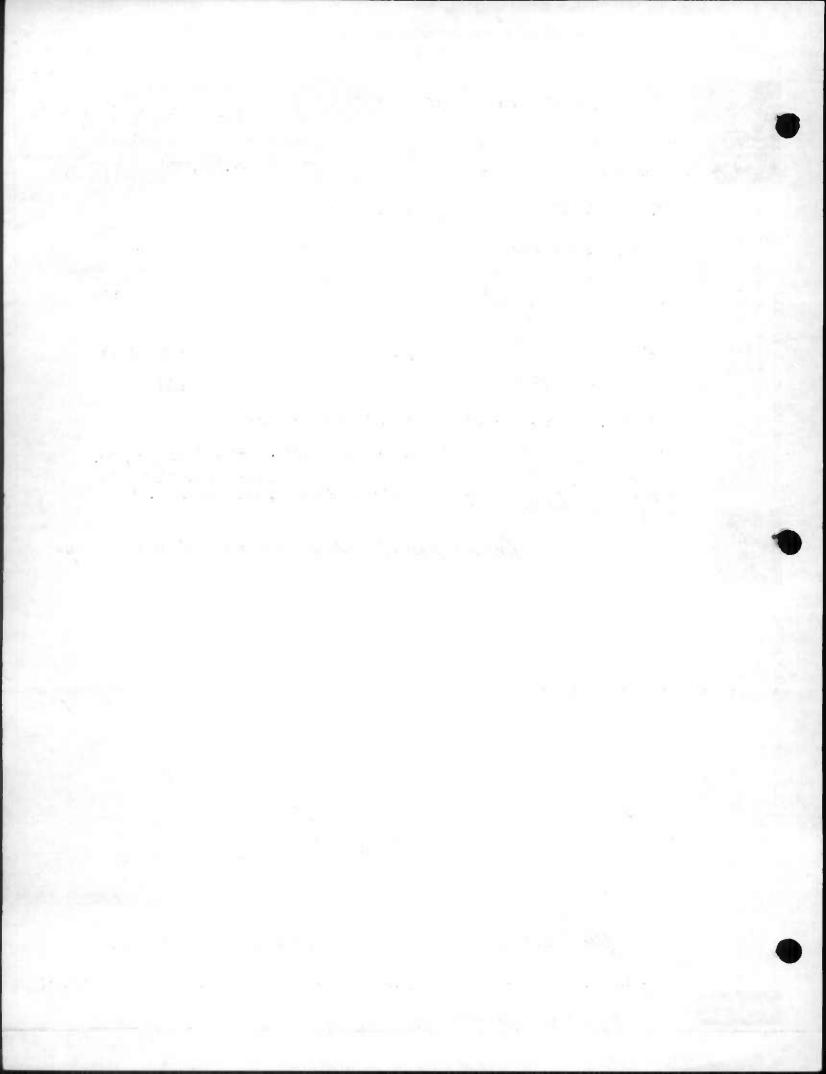
		Certificate of Death	Reg. No.	00234					
DI:	1. Decedent's Name (First, Middla, Last)		2. Dete of Death Month Dey Year	3. Time of Death					
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Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or L							
24 T	36421 Old Ocean City Rd.	Willard							
Funeral Director	5. Social Security Number  084-22-1771  Usual Residence of Decedent  6. Sex  1 M 2 D F  7. Age (In yrs. las	st birthday) Yrs.  If Undar 1 Yaar If Under 24 Hrs. Months Deys Hours Min.		rthplace (State or Foreign Country) SSACHUSETTS					
and and	the same of the sa	Town or Location		10d. Inaide City Limits					
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with the Ma 3a or 28a-f s is be notified		101. Zip Code 21874	10g. Citizen of What C USA	Country?					
Maryland ZIZID-UUZU  42 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiena.  7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Exerting must be notified.  To Be Completed by Funeral Director.	11. Mental Stetus  1 Nevar Married 2 Married  3 Widowed 4 Divorced  12. Was Dacedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Yaar or Datas:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2▼ No Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No- Bleck, White						
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death certificate be executed e attending physician and of for use as the burlei-fransit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	s a consequence of): s e consequence of): s a consequence of):	che.	gan					
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Hospi 4 hou Funer tely fill	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle cone (Check only one)  1 Medical Examiner: On the basis of examination and manner stated.	judge, deeth occurred at the time, date end place, and/or investigation, in my opinion, deeth occur	end due to the cause(s) and manner a red at the time, date and place, and du	es stated. ue to the cause(s)					
within 2 To the comple	29b. Signeture and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)					
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.1	30. Name end address of person who completed cause of death (Item 23	3a) (Type, Print)	1 1 1/00						
4		Healthway Dr., Salisbur	ry, MD 21804						
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signetur								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day Year **Physician** DARLENE HUTT MITCHELL 2000 9:55 PM /Medical Jan 28 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot Genesis ElderCare -The Pines If Under 24 Hrs. 8. Date of Birth Hours Min. JAWontin 249, 149/155 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 SALISBURY **Funeral** 1□ M 2♥ F Months Deys 45 215-62-1333 Director Usual Residenca of Decadent with the Maryland 10a State 10b. County 10c. City. Town or Location Show 10d. tnside City Limits the Medical Examiner must be notified at WICOMICO MD. Director SALISBURY 1 Yes 2 No itsms 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8615 JERSEY ROAD 21801 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Peges 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give natural, or Darlene Mitchell Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) end Mental BOBBY WATSON is marked 2 THELMA HUTT 19e, Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Depertment of Health er Important: If Itam 27 is any Injury or other trau once. JAMES A. MITCHELL/HUSBAND ADDRESS SAME AS ABOVE 20e. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State SPRINGHILL MEMORY GARD. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-4 000 HEBRON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licans 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximete interval Between Onset end Death Physician Breast cancer, metastatic to brain and hours Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequenca ot): Box 68760. Due to (or as a consequenca ot) 98 P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 □ Probabty 4 ☑ Unknown Records, þ 24b. Were autopsy findings evailable prior to Completed 24e. Was an autoosy peen completion of cause of death? pege 2 hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: A Hospital ...
in 24 hours effer deem.
the Funeral Director: After this or P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of tnjury (Month, Day Year) Certification: 28b. Time of 28c. Injury a Work? 28d. Describe how injury occurred Division 1. Netural 5 Pending Investigation 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier edical completely (Check only one) within 2 94 29b. Signature and title of pa 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508 MD DUEWILD 32. Registrar's Signature 31. Dete tiled (Month, Day, Year) State Registrar B. Sparks



# Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

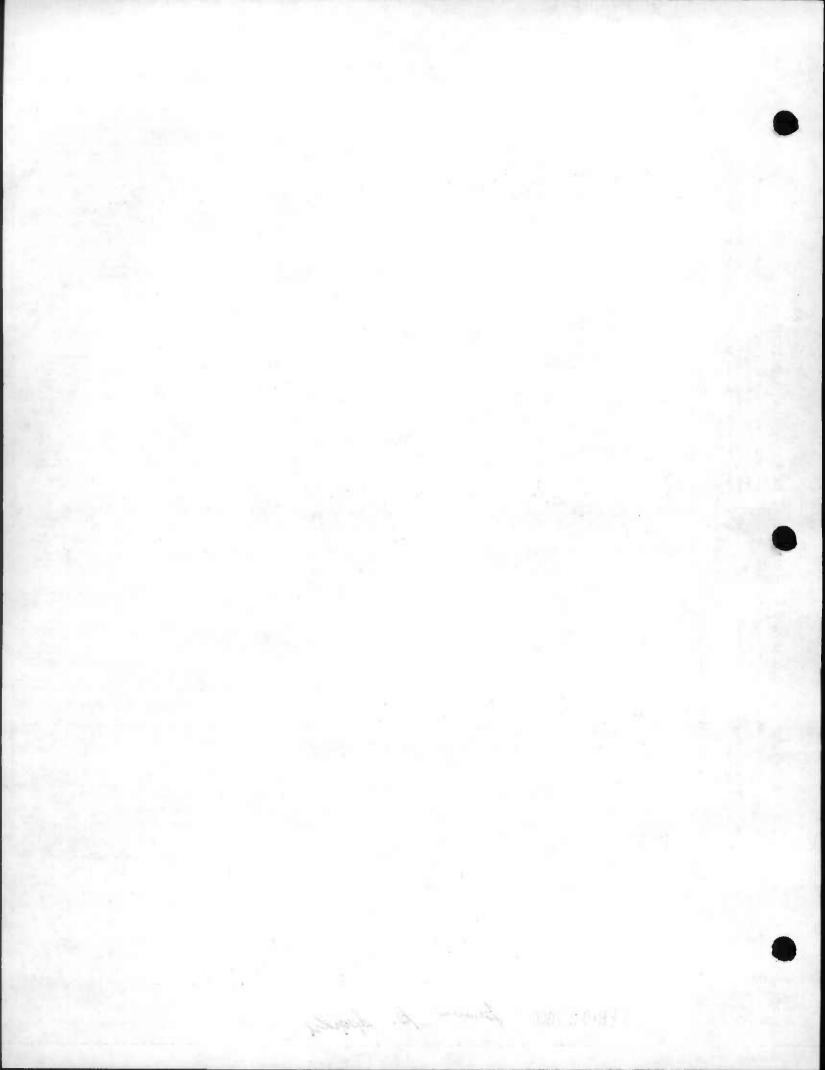
				Certificate o	f Death		Reg. No.	0 05296	
Physician						2. Date of De Month	ath Day	3. Time of Death	
								000 12:18 P.M.	
Examiner	4a Facility Name (If not institution,	give street and number	)		4b. City, Town, or	Location of Deat	4c. County	of Death	
Funeral				hday) If Under 1 Yes		8. Date of Bir	th	9. Birthplace (State or Foreign Country)	
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h the	10e. Street and Number			10f. Zip Code			10g. Citizen of 1	What Country?	
Day of the case of	10746 Flower St			21	811		U	.S.	
02(	Harry Morris  4a Facility Name (If not Institution  Berlin Nursing  5. Social Security Number  219-07-7260  Usual Residence of Decedent  10a. Stata 10b. County  MD Word  10e. Street and Number  10746 Flower St  11. Marital Status  1 Naver Married 2 Marriad  3 Widowed 4 Divorced  (Specify only highest  Elementary/Secondary (0-12)  9 th  17. Father's Name (First, Middle, Simon Leonard  19e. Informant's Name/Relations  Vanessa M. Purriad  20a. Method of Disposition  120 Buriat 2 Cremation  121 Signature of Funaral Service  21. Signature of Funaral Service  22. Sequentially list conditions, if any, teading to immediate cause (Finat disease or condition resulting in death)  22. Sequentially list conditions, if any, teading to immediate cause (Finat disease or condition resulting in death)  23. Was case or injury that initiated events resulting in death) Last  24. Buriat 2 Cremation  25. Was case or injury that initiated events resulting in death) Last  25. Was case or injury that initiated events resulting in death)  26. Was case or injury that initiated events resulting in death)  26. Was case or injury that initiated events resulting in death (Check only only 10 Medical investigation of the condition of the cond	Armed Forces	?			Specify Yes or No to Rican, etc.)	Blad	e - American Indian, ck, Whita, etc. v: Black	
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Examiner	disease or condition resulting in death)	b	Due to (or as a c	onsequence of):	Limboli	a lekzl	umer	Type 6 yes.	
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Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	arterisco	levolie	Carl	iovoseu	elan	24a. Was	an autopsy ormed?	24b. Were autopsy tindings available prior to completion of cause of death?	
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To the Hospital or within 24 hours after within 24 hours after completely filled in Medical Cert	Decedency Numeric (1982) Models (1887)   Decedency Numeric (1982)   Decemend (1982)   Decem	ceuse(s) and m date and place,	ie(s) and manner as stated. and place, and dua to tha cause(s)						
Within Comp	29b. Signature and title of certifier	10	~	29c. Lice	ense number		29d. Date signe	d (Month, Day, Year)	
	Segment advanced parents	Mr. Bel	Carl (Itam 22a)					-2000	
3	GREGORIO H	Ab. City.   Sing & Rehabilitation Center   Sing & September   Sing & Septembe	AREPOY	110-968-1801					
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Registrar

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FFB 0 2 2000

ORIGINAL



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6207 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year Month **Physician** CHARLES 22,2000 AVELIN 4:10 AM Jan. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Center; Genesis ElderCare Salisbury, Wicomico Md. 8. Dete of Birth (Month, Day, Year) JULY 25, 1906 If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WEST VIRGINIA 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours Yrs. 338-09-6930 93 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 107 MAY DR. 21804 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Yeer or Detes: Berna 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Never Merried 2 Married 8 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER BRAKE MANUFACTURER 12 4 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be CHARLES ELMER MORGAN DAISY TOCAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Hitsem 27 is or other trax JOHN W. YARBOROUGH 107 MAY DR. SALISBURY, MD 21804 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) PARKLAWN MEMORIAL PARK 1/25/00 HAMPTON, VIRGINIA 705 E. MAIN ST. 22. Neme end Address of Fecility 21. Signature of Funerel Service Ligenses CFSP BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Pert1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or conditio resulting in death) Mar Examiner Due to (or es a consequence of): Examiner ician and burial-transit -1 us Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) 11 learance Physician/Medical the Due to (or es e consequence of): 888 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en autopsy 1 Yes 2 No 1 TYes 2 No 25. Wes case referred to medical examiner? Be 26. Piace of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Netural 5 Pending investigation

that the death certificate be executed P.O. Box 68760 signed be det Records. The law requires certificate Division of Vital or Attending Physician:

The Mandand

hours after

filed within 72

Pages 1 and 2 should be nent of Health and Mental

altimore, Maryland 21215-0020

Medical Certification: To

5

6 ☐ Could not be 3 ☐ Suicide 4 Homicide 29a. Certifier

2 Accident

(Check only one)

29b. Signeture and title of certifier

28e. Dete of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D., 1204 HEALTHWAY DR, SALISBURY, MD. 21804 31. Dete filed (Month, Day, Year) 52. Registrar's Signeture

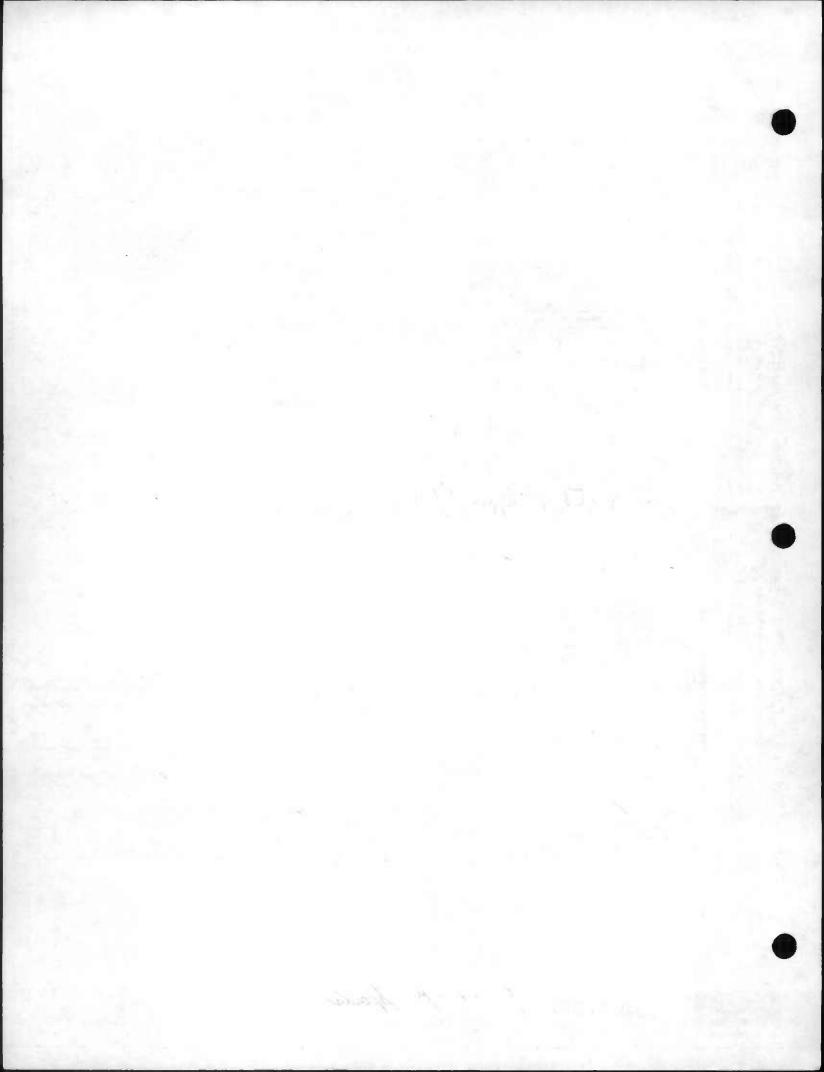
State Registrar

24 hours after death.

within 2 \$

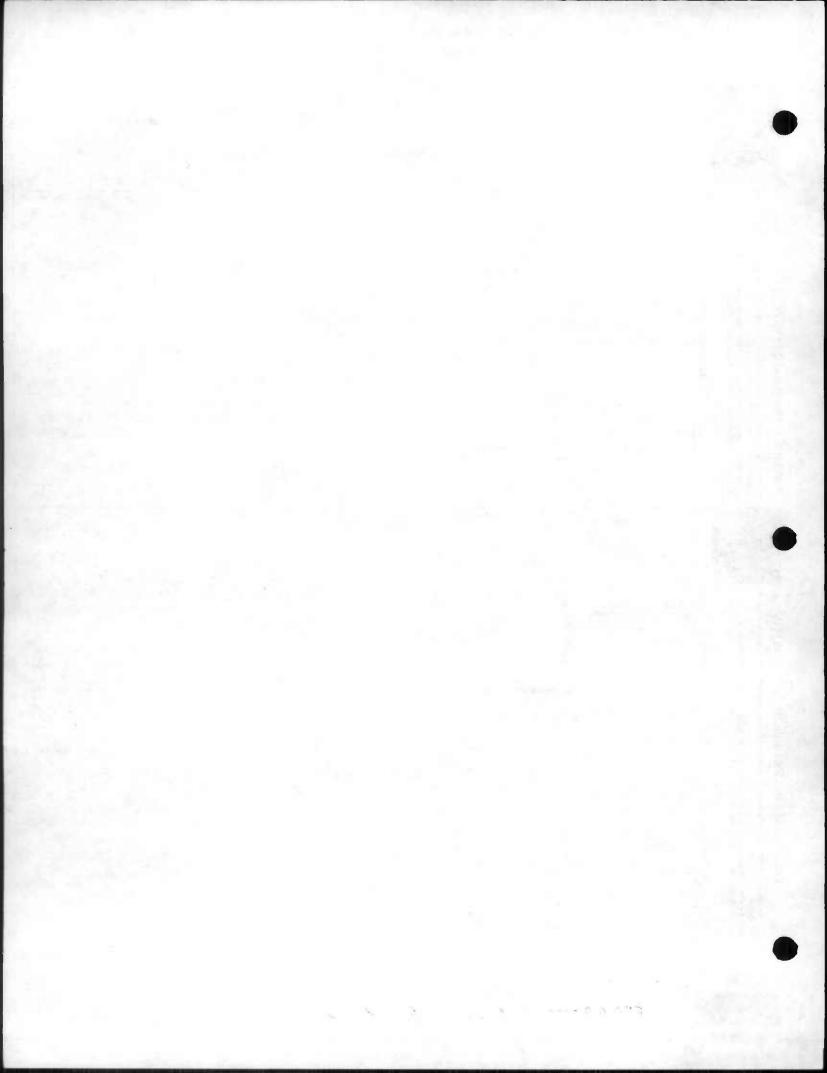
Hospital

filled in by



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate o	f Death		F	leg. No.	U	5298	
Dhunin		1. Decedent's Name (First	, Middle, La	st)						2. Dete of Dea	ith Dey	Year	3. Time of Deeth	
Physici /Medi		Louis		E.	Miles	Mart	in				5, 200		02:00am	
Examir		4a Facility Name (If not in	stitution, giv	e street and numb	per)			4b. City, To	wn, or L	ocation of Death	4c. County	of Death		
		Memorial						Cumb					egany	
Funeral Director		5. Social Security Number 214-05-41 Usual Residence of Deced		ex 7.	Age (In yrs. I	-1-1-1-1	Months Day		24 Hrs. Min.	8. Dete of Birti (Month, Day Oct 3	(, Year)	9. Birth	place (State or Foreign htry) MD	
5-0020 72 hours shar death with the Maryland natural, or leans 23s or 23s-1 show dieal Examinat must be notified at sted by Funeral Director	10a. State 10b. County 10c. City, Town or Location										10d. Inside City Lim			
	octo	MD	Alle	egany		Cu	-						1 Yes 2 No	
											10g. Citizen of V USA	Vhet Cou	ntry?	
	by	11. Marital Status  1 Never Married 2  3 Widowed 4 Di		12. Was Deced Armed Force 1 Tes 2 If Yes, Give Year or Date	es? □ <b>X</b> o		Was Decedent of Yes, specify Co			ecify Yes or No- Rican, etc.)	14. Rac Bled Specify	k, White,		
5-0 72 ho	pet		cedent's Ed			16a. Dece	dent's Usual Occ kind of work do	cupation	t of work	ina	16b. Kind of Bu	ısiness/in	dustry	
Within Within the Me	Completed	Elementary/Secondary (		de completed) College (1-4	lor 5+)	Sale	DO NOT USE TEL	ired)	or work		Montgomery Ward			
D High	Be C	17. Father's Name (First, I	fiddle, Last)	Q E T		Dulo		18. Mothe	er's Nem	e (First, Middle,		-		
land by the standard by the st	ToB	Samuel A.	Mart	in				Ada	F	(Bise	el)			
Mary d 2 abox th and h		19a. Informant's Name/Re Charles L		,, ,						al Route Numbe			Code)	
Hoan 2		205. Method of Disposition			20b. PI	lace of Dispo	sition (Name of			Dete	20c. Location -			
altimore mit. Paper 1. partment of Hy portment of H		1 Burial 2 Crem 4 Donation 5 0	ation 3		ate		natory or other p							
High and a second					St	Pat	rick's	Ceme	tery	72/08/	Cumber	rlan	d, MD	
B Page		21. Signature of Funeral/Service Licensee  22. Name end Address of Facility Scarpelli Funeral Home P.A Cumberland, Maryland 2150												
		23a Part Fotor the disa		1 200	11214						21502	2	Approximete	
V		23a. Part1. Enter the disease, or complications that cause it he death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.  Approximate Interval Between Onset and Deeth												
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure  Unknown  Due to (or as a consequence of):												
Examiner														
	ě								01.		. D 1	1	IIl a	
68760, ficate be axecuted physician and se the buriel-transit	Examiner	Sequentially list condition		b. Aspirat				nronic	UDS	tructiv			Unknown	
axe axed												56		
68760, fficate be associted g physician and es the buriel-transit	edical	Cause (Disease or injury that initiated events	5	C	Due to (or	as a conseq	uence of):					-		
	800	resulting in death) Last												
NOX th cer	2			d								1		
d to de do	90	Part II. Other significant c	onditions o	ontributing to deal	th but not resu	ilting in the u	nderlying cause	given in Pert I	1.	23b. Did tobacco use contribute to the cause of deat				
D. O by the	Phy	Anomia Co	lan Ma	1:00000							1 Yes 2 No 3 Pr			
S s th		Anemia, Co	LON Ma	irrgnancy					_					
cord * requir	petel							31		24e. Wes	en eutopsy med?	94	fere autopsy findings reilable prior to ompletion of cause death?	
Re la has	E									101	es 2 No		☐Yes 2☐No	
in: T		25. Was case referred to r	nedical		-			26 Place	e of Deet	th (Check only o				
S condition	0	examiner?		Hospital: 1 Inc	etient 2 1	ER/Outpatier	t 3 DOA	Other		ome 5 Resid		er (Speci	(v)	
DIVISION of VITAI RECORDS, P.O. BOX is or Attanding Physician: The law requires that the death cert in after death.  To Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be datached for use a Certification: To Be Completed by Physician/M		27. Manner of Death	Pending investigation	28a. Date of (Month,		28b. Time of Injury	28c. Ir				now injury occur			
- 502>	rtifica	TO PRODUCTION	Could not be determined	28e. Place of	I Injury - At ho , etc. (Specify		eet, fectory, offic			28f. Location (S City or Tox	Street and Numb m, State)	er or Run	al Route Number,	
D SE														
n 24 ho	edical			ysician: To the be niner: On the basi and manne										
To the	2	29b. Signature and title of	centry	1/1/1			29c. Lice	ense number			29d. Date signe	d (Month,	Day, Year)	
	0	1/m	U,	1101			D30	197			Februa	ry 8.	, 2000	
E	0	30. Name and address of p	version who	completed cause	of death (Item	23a) (Type,								
2	>0	br. Kenneth	Rock,	Memorial	Hospi	tal.	Suite 40	2. Cum	berl	and, MD	21502			
Sta Registr		31. Date filed (Month, Day) FEB ()	Year)	32. Reg	istrar's Signat	ture	lon "							



Amended # 196 20c Allaging County 2/5/00

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / De

epartment of Health and	Mental Hygiene	0520
Certificate of Death	Reg. No.	002.2

2. Dete of Death

Month

Physician
/Medical
Examiner

1. Decedent's Nama (First, Middle, Last) AUDREY M. MC DONALD

rebruan 4a. Fecility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death

7. Age (In yrs. last birthdey)

79

3. Time of Death 23.40 6, 200

9. Birthpiece (Stata or Foreign

LIONS MANOR NURSING HOME 5. Sociel Security Number

6 Sex

ALLEGANY

1 M 2 X F

CUMBERLAND If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) SEPT 11,1920

4c. County of Deeth ALLEGANY

**Funeral** Director

the Medical Examiner must be notified at

Important: If item,27 is m any injury or other traum once.

Department of

Physician

/Medical

Examiner

bunal-transit

attending physician for use as the buna

signed by the at d be deteched for

certificate hes b

director

After this tha funeral þ

Completed

Be

2

Medicai

Director

Funeral

þ

Completed

Be

Usual Residence of Decadant 10e. Stata 10b. County MARYLAND

220-38-2325

10c. City, Town or Location LAVALE

Yrs.

VIRGINIA 10d. Inside City Limits 1 ☐ Yas 2 No

10e Street and Number

12 MCKENZIE ROAD

10f. Zip Code

10g. Citizen of Whet Country?

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Stetus

21502 Was Dacedent of Hispanic Origin? (Spacify Yes or No-if Yes, specify Cuben, Maxican, Puerto Rican, etc.)

USA 14. Rece - American Indien, Bleck, Whita, etc.

1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 □ Divorced

1 ☐ Yes 2 K No Specify:

Specify: WHITE

15. Dacadent's Education (Specify only highest grade completed)

Collega (1-4or 5+)

Year or Dates:

16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired)

16b. Kind of Business/Industry

Elamantary/Secondery (0-12)

HOUSEWIFE

OWN HOME

17. Fethar's Neme (First, Middle, Last)

EARL HERRELL

18. Mother's Name (First, Middle, Meiden Sumama)

SYLVIA JENKINS

19a. Informant's Neme/Reletionship (Type, Print)

EARLENE MCKENZIE/DAUGHTER 196

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FROSTBURG, MD

20e. Mathod of Disposition

1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) ECKHART CEMETERY

20c. Location - City or Town, Stete F E B 10,2000 ECKHAT,

Signetura of Funerel Service Licensee

22. Name end Address of Fecility

HAFER CHAPEL OF THE HILLS MORTUARY 21502

23a. Part1. Enter the dimense, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition rasulting in deeth)

Dua to (or es e consequence of)

Cerebrovas Cular accident

Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Diseese or injury that Initiated events rasulting in deeth) Last

Dua to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings eveileble prior to 24e. Wes an eutopsy performed? completion of cause of deeth?

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No

26. Pleca of Death (Check only one)

1 ☐ Yas 2 ☒ No

25. Wes case referred to medical 1 Yes 2 No

5 Pending investigation

6 Could not be datamined

1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Tima of

28c. injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Menner of Deeth

1 Natural

2 Accident

3 ☐ Sulcide

4 | Homicide

28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only

1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at tha time, dete and place, and dua to the causa(s) end menner stated.

29b. Signature and title of certifiar

29c. Licensa number

29d. Data signad (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

V. A. Ranjithan, MD 1 31. Dete filed (Month, Day, Year)

Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21562 32. Registrer's Signeture

FEB 0 8 2000

State Registrar

DHMH 16 Rev 6/95

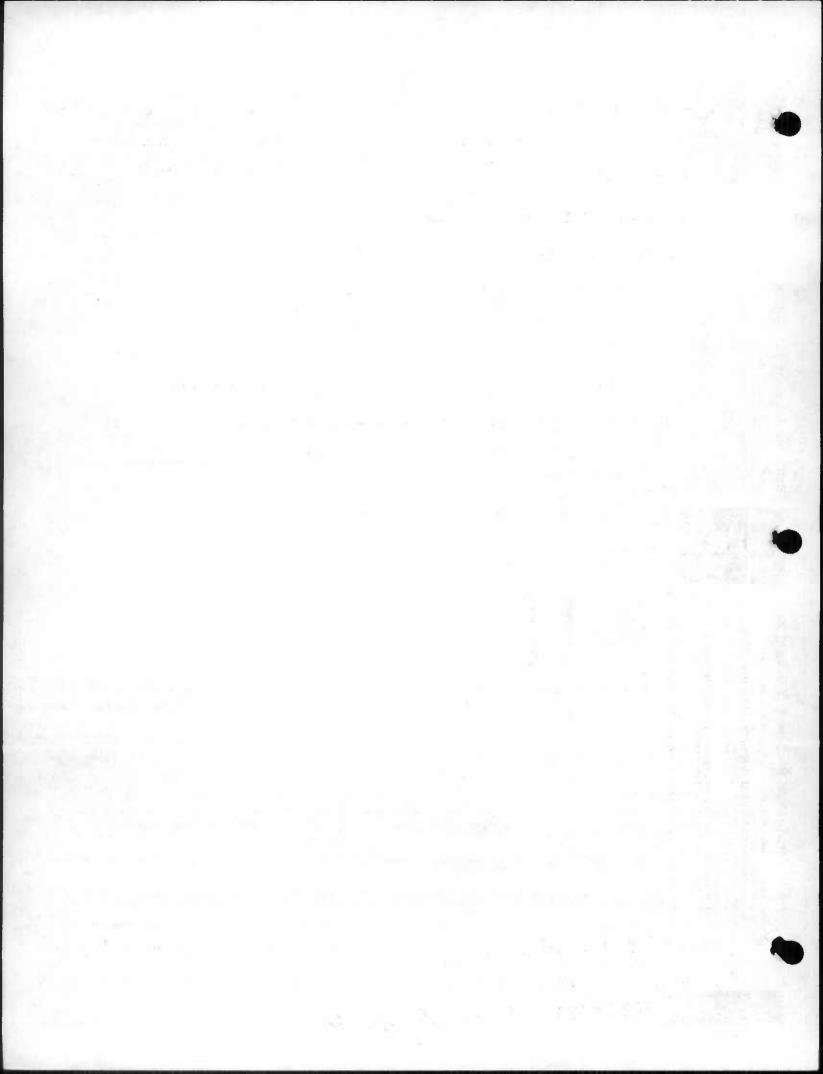
28a-f show 23a or or items Hygiena. other than "naturel",

altimore, Maryland 21215-0020 McDonald Z

> The law requiras thet tha death certificate be assecuted Box 68760, P.O. I Records, Division of Vital or Attending Physician:

within 24 hours after death.

To the Funeral Director: At completely filled in by the fu the Ri



State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of	Death			Reg. No.	V	00300		
		1. Decedent's Neme (First, Middle, L.	est)						2. Dete of De		Vans	3. Tima of Death		
	Physician /Medical	FRANKLIN H. N	MILLER, SR						Month Febru	Dey ary 7,2	Yeer	0020 a.m.		
	Examiner	4a Facility Name (If not institution, gi		)					ocation of Deet	h 4c. County	y of Death			
		SACRED HEART HO	SPITAL				CUMB		ND	ALI	EGAN:	Y		
	Funeral Director	215-20-5817	Sex 7. A 1 1 M 2 □ F	ge (In yrs. last birth 75 Y	rs. If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De Sept. 2,	th ly, <i>Year)</i> 1924	9. Birthp Cour MARYI	place (State or Foreign http) AND		
	bud *	Usuel Residence of Decedent  10a. Stete 10b, County		10c. City, Town	or Location						1	10d. Inside City Limits		
	vith the Maryl t or 28a-f aho be notified a	MD ALLEGA	ANY	LAVA						1 X Yes 2				
	with the	10e. Street and Number			10f. Zij					10g. Citizen of		itry?		
	na 23	613 N. SECOND S	12. Wes Decedent	Ever in ITS		2150		nin? /Sn	poity Ves or No	U.S.A	ce - Americ	can Indian		
020	be filed within 72 hours after death with the Maryland stal Hygiene.  If other than "natural", or items 23a or 28-4 show event, the Machell Exeminer must be notified at event, the Machell Exeminer must be notified at Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces'  1	? No	13. Wes Dece If Yes, spe			, Puerto	Rican, etc.)	Specif.	ck, White,	etc.		
2-0	72 ho	15. Decedent's E (Specify only highest gr			Decedent's Usu (Give kind of wo			t of work	ina	16b. Kind of B	usiness/In	dustry		
21215-0020	led within 72 ho tygiene. Wr then "neturn it, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Me. DO NOT U	se retire	d)			RAILF	ROAD			
Maryland		17. Father's Name (First, Middle, Las. CHARLES MILLER	)						B. HAGI	, Maiden Surnar ER	me)			
	and 2 should salth and Men n 27 is marke set treumatic.	19e. Informent's Neme/Relationship RUBY H. MILLER								er, City or Town		Code)		
Baltlmore,	of H	20a. Method of Disposition  1 Disposition  1 Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  MSVC — ROCKY GAP  2/								20c. Location - City or Town, State  FLINTSTONE, MD				
Baltimoperation Page Department Important: Inspectant: Inspectant	21. Signeture of Funeral Service Lice	21. Signeture of Funeral Service Licensee  22. Name end Address of Fecility UPCHURCH FUNERAL HOME, P. A. 202 GREENE ST., CUMBERLAND, MD 21502  23a. Pertl. Enler the elseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate												
		23a. Pert1. Enter the disease, or con shock, or heart tellure. List only	plications that cause	d the deeth. Do no							21302	Approximete Intervel Between		
1	Physician	onson, or near tonors. East only			. 1			-	) -			Onset end Death		
	/Medical	Immediate Cause (Final disease or condition	. ADV	ANCED	METH	+57	ATIC	1	ROST	ATE		> 4 years		
		! resulting in deeth)		Due to (or as e co	onsequence of)		(	CAI	RCIN	OMA		0		
o,	en and iriel-trens	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	0.	Due to (or as e co	onsequence of):				41 -119			- J- D- W		
68760	indificate be executed in polysician and as the buriel-trensit	thet initiated events resulting in deeth) Last				A GE								
Вох	ath ce attendi for use		d											
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<b>a</b>	hat it detac								1 🗆	Yaa 2 No	3 Pro	bably 40 Unknown		
Records,	been s should leted								performed? evaile comp			era autopsy findings railable prior to empletion of cause death?		
Re	The lay								10	Yes 20 No		☐ Yes 2☐ No		
Ø	ysician: The li s certificata ha director, page To Be Com	25. Wes case referred to medical					26 Place	of Deet	h (Check only		1	2010		
5	hysicianis certification direct	examiner? 1 Yes 2 No	Hospitel:	ent 2 ER/Out	patient 3 De	OA Oti	her	ron II		dence 6 Oti	her (Specil	(v)		
Division of Vital	2 2 2	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Dete of Inju (Month, Da	ury 28b. Ti		28c. Inju Wo				how injury occu				
DIVIS	to a standing P as after death.  I Director: After tied in by the funantied in by the funantied certification:	3 ☐ Suicide 6 ☐ Could not to determined	200. Place Of In	jury - At home, fen ic. (Specify)	m, street, fector	y, office			28f. Location ( City or To		ber or Ruri	al Route Number,		
	To the Hospital of within 24 hours a To the Funeral D completely filled i	29a. Certifier Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis o end menner st	f examination and	death occurred for investigation	et the ti	me, date an opinion, dea	d place, th occurr	end due to the red at the time,	cause(s) and m date end plece,	anner as s and due to	tated. o the ceuse(s)		
		29b. Signature and this of certifier	Jan	~	29		se number			29d. Dete signe				
	16/3	30. Neme and address of person who	completed cause of	death (Item 23a) (T	Type, Print)	100	ו ככא	1		Februar	гу8	, 2000		
1,	(AL	DR Q. Zaman	425	Kent A	ve #10	sa.	Cum	Der	land,	mo	2150	6		
	State Registrar	31. Dete filed (Month, Day, Year) FEB 1 0 2	. 4	rer's Signeture			les							

TER 16 78 M. Lemma 10 feet in

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Dev **Physician JOANNE** JANUARY 29, 2000 04:12 A.M. MOYERS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 24 Hrs. 8. Date of Birth (Month Day 1 Year) May 21, 1932 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 20√F Months Hours Westy) Virginia 67 234-46-6745 Director **Usual Residence of Decedent** 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits se filed within 72 hours after death with the Merylen al Hygiene.

Il Hygiene.

Indirer then "netural", or flerne 23s or 28s-f show in which the mortified is not the mortified in verif, the Medical Energine in mortified in Rawlings Yes 2 No Allegany MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21557 P.O.B 227 Blommingfield Trailer Court Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify.White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mobil Home Park Management permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Itam 27 is marked other th any injury or other traumatic avant, that once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) 8 Bertha Louise Ravenscroft Henry Bruce Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 227 Rawlings, MD 21557 Berlin F. Moyers/Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【\*Cremation 3 ☐ Removel from State 1/31/00 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 21. Signature of Funerel Service Licensee. 22. Name and Address of Facility Upchurch Funeral Home, P.A. 5-Mark 202 Greene St. Cumberland, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examin nevery physician and the burlai-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): the attending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tohacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown Corcinna Colon, Division of Vital Records. P 24b. Wera autopsy tindings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? After this cartificate has funarel director, page 2 1 Yes 2 No 1 Tyes 2 No 80 25. Wes case referred to medicat 26. Place of Death (Check only one) Hospitet: 1 Linpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: or Attanding 5 Pending investigation 1 Naturat a after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certified JANUARY 3/ on who completed capse of death (Item 23a) (Type, Print) Mas . 912 umberland MD State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be Department of Health and Mental Important. If item 27 is marked any injury or other traumatic elected.			metion 3 [	20b. Place of Disposition (Name of cemetery, cremetory or other place)						Dete 20c. Location - City or Town, Stete			
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0.	the atter	sicle	Pert II. Other aigniticant	conditione o	ontributing to de	ath but not	resulting in	the underly	ving cause giv	ven in Pert I.	23b. Did t	obacco use co	ntribute to	the cause of death
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	within 24 To the Fu completel	M	29b. Signature end title of	cegulier	7				29c. Licens	31546	,			
	4+1VA		30. Name and address of	person who	completed cause	of death (I	w		10.00	Pane				
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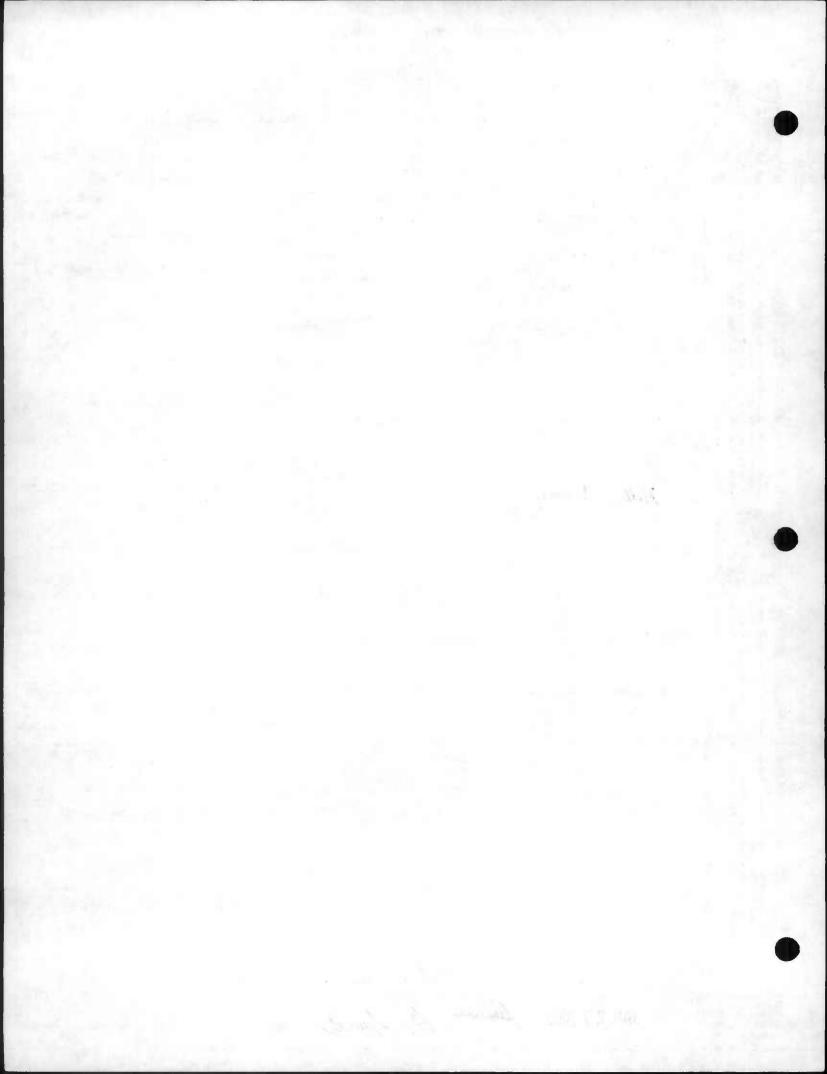
En la standarde

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** GORDON GILHAM NOBLE 24,2000 JAN. 6:05AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD. WICOMICO If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Yrs Director 214-05-0942 90 February 15,1909 Virginia Usual Rasidence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at 1 Vas 2 No Director Wicomico Maryland Salisbury 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a or 305 Calvin Drive 21804 death USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Maritat Status 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian. Black, Whita, atc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: 8 Baitimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Vice President Insurance marked other 17. Fathar's Nama /First Middle | ast) 18. Mothar's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be filment of Heelth and Mental Hant: If item 27 is marked oth lury or other traumatic aven Be Twiford Wright Noble Jenny Giles 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Dorothy G. Noble/Wife 305 Calvin Dr., Salisbury, MD 21804 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) St. Margarets Church Cemetery 1/29/00 Annapolis, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funaral Service Licensee Keith R. Nouvey 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final ary disaasa or condition rasulting in death) med Examiner Examiner the deeth certificate be executed physicien and the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last noe of) Box 68760. Physician/Medical Dua to (or as a consequence of): 980 O signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ The lew requires been si 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to Completed completion of cause of death? page 2 s 1 Yas 2 No 1 Yas 2 No certificate Division of Vital Physician: 25. Was casa referred to medical examinar? Be 26. Place of Death (Check only ona) To Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 2 ☐ Accident 24 hours after deat Funeral Director: 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) à 4 Homicide filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License numbe 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) DAM 1104 HEALTHWAY DR., SALISBURY, 21804 WILLIAM ROBINS, MD. M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signatura State JAN 2 7 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** Ethalind W. Neal 0950 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street end number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY Hours Min. 8. Dete of Birth (Month, Day, Year) 8-8-1920 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ■ M 2 A F 220-10-9803 79 Md. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at XX Yes 2 □ No Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1016 Pierce AVe. 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Merried 2 □ Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If fism 27 is marked other that any Injury or other traumatic avent, train page. 9 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Henry Adkins Elva White Adkins 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Scott, Daughter 1415 Emerson Ave. Salisbury, Md. 21801 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-28-00 Parsons Cemetery Salisbury, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Short Funeral Home, Inc. 23a. Part1. Enter the dissesse, or complications that ceuse of the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 13 E. Grove St. Delmar, De. 19940 Approximate Interval Between Onset and Deeth **Physician** Anterior derotie Heart Essase /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 0 No 1 ☐ Yes 2 ☐ No certificata of Vitai or Attending Physician: funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menger of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division 1 Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ware FA-5 d cause of death (main 23a) (Type, Print) e and address of serson who compl Evangelista U.E 31. Date filed (Month, Dey, Year)

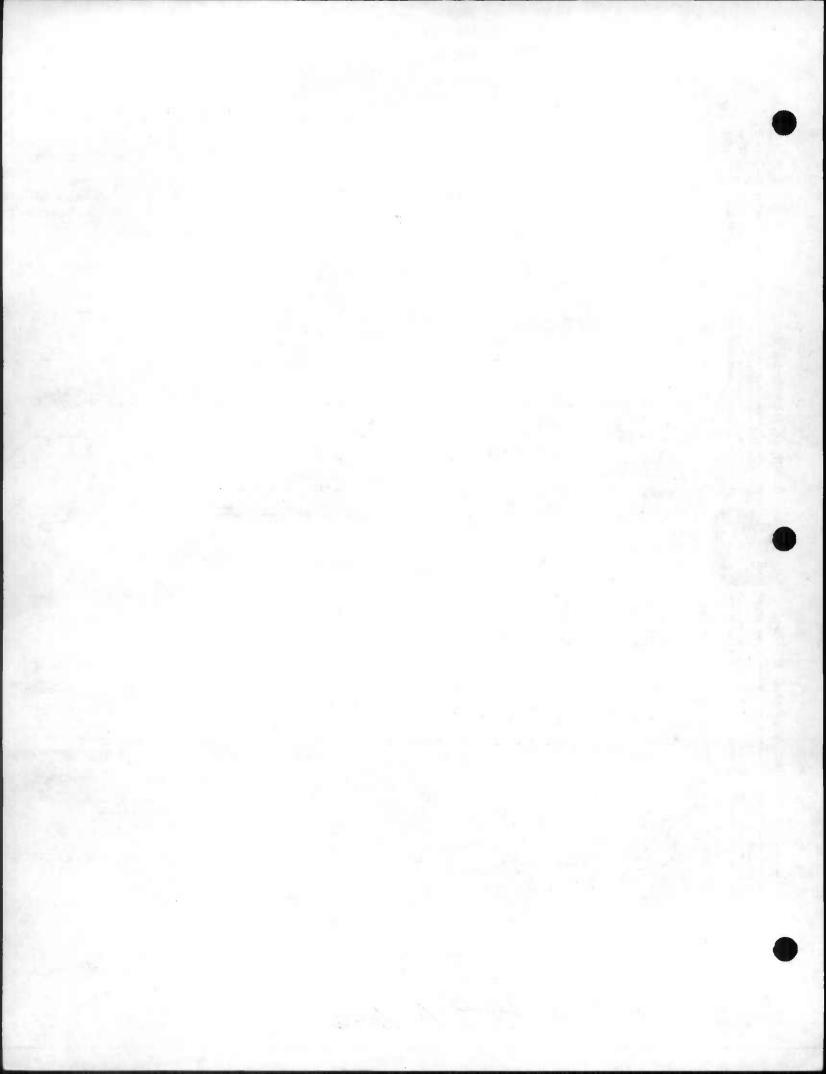
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**DHMH 16 Rev 6/95** 

Registrar

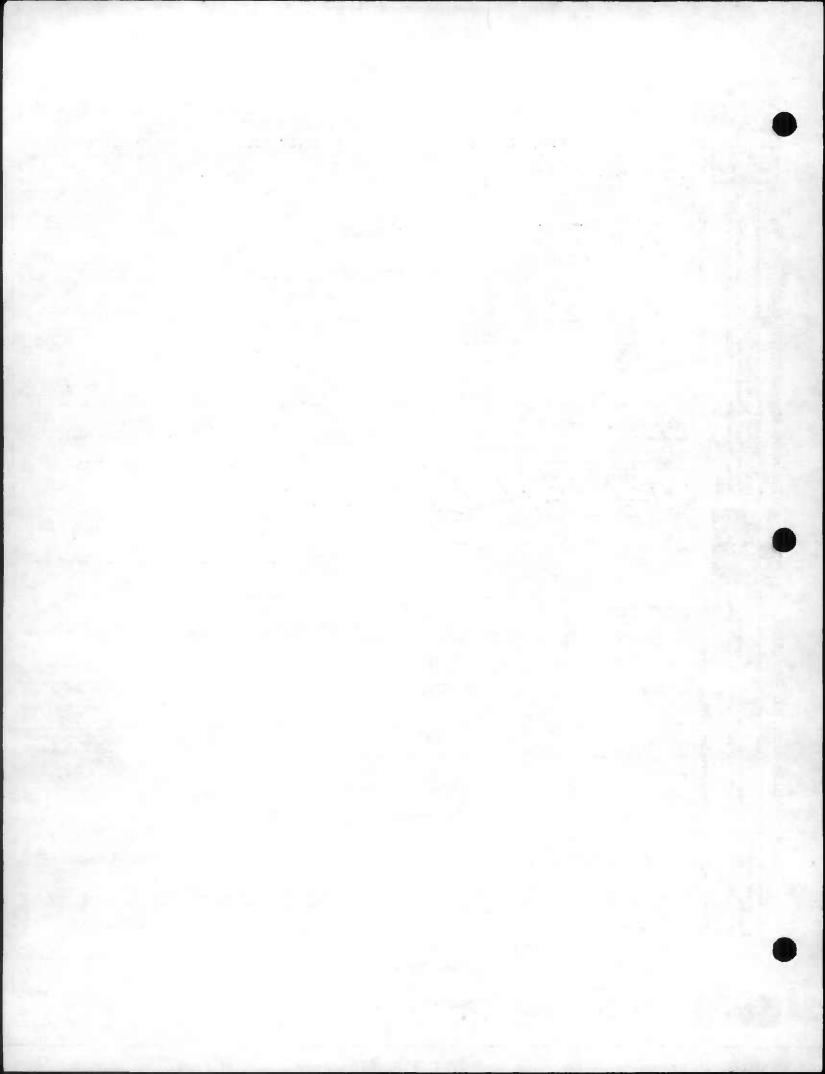
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State of Maryland / Department of Health and Mental Hygiene 10 05305

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Examiner	4a Facility Nama (If not institution, giv	re street and number)			4b. City, Town, or	Location of Death	4c. County						
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Funeral			(In yrs. last bir	thday) If Und Month	der 1 Year s Days			Birth 9 Birthplace (State					
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fler death viner all short must	11. Merital Stalus	12. Was Decedent E	ever in U,S.	13. Was Dec			Specify Yes or No- to Rican, atc.)	14. Race	- Amaricar	n Indian,			
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12 st	19a. tnformant's Name/Relationship (								ty or Town, Stata, Zip Code)				
Seattly Mark	Lillian K. Offutt	/ wife				Rd., Woo	odsboro,						
200 m 0	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆	Bernoval from Stale	20b. Place o	f Disposition (A ry, crematory o	rama or or other pla	ce)	Data	20c. Location -	City or Tow	n, Stata			
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SOLES	PEDIEB	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702											
	23a. Part1. Enter the disease, or complications that caused 99 death. Do not enter the mode of dving, such as cardiac or respiratory arrest.  Approximeta												
	shock, or heart tailura. List only one cause on each line. Onset and Death												
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To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29b. Signature and title of certified			2	9c. Licens	se number	2	9d. Data signed	d (Month, D.	ay, Year)			
	M	CM.			73	7171	PERM	031	07/00				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								-1100				
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	RICHARD L.	22 72	SSimplification	258			NO 2179	2					
State Registrar	31. Data filed (Month, Day Year) FEB 0	8 2000	1	. 10.	19	oute							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death February 6, 2000 Physician 01sen Anita Paulina 4:20 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Months 10 M XXF 094-20-6670 Director May 23, Ohio Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Haelih and Menial Hyglens. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Maddel Examiner must be notified and anota. Maryland Frederick Frederick 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9033 Mountainberry Circle 21702 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemical/Supplies Sales Representative Baitimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cabo Luis Violet Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura L. Olsen, daughter 9033 Mountainberry Circle, Frederick, Md. 21702 20a. Method of Disposition

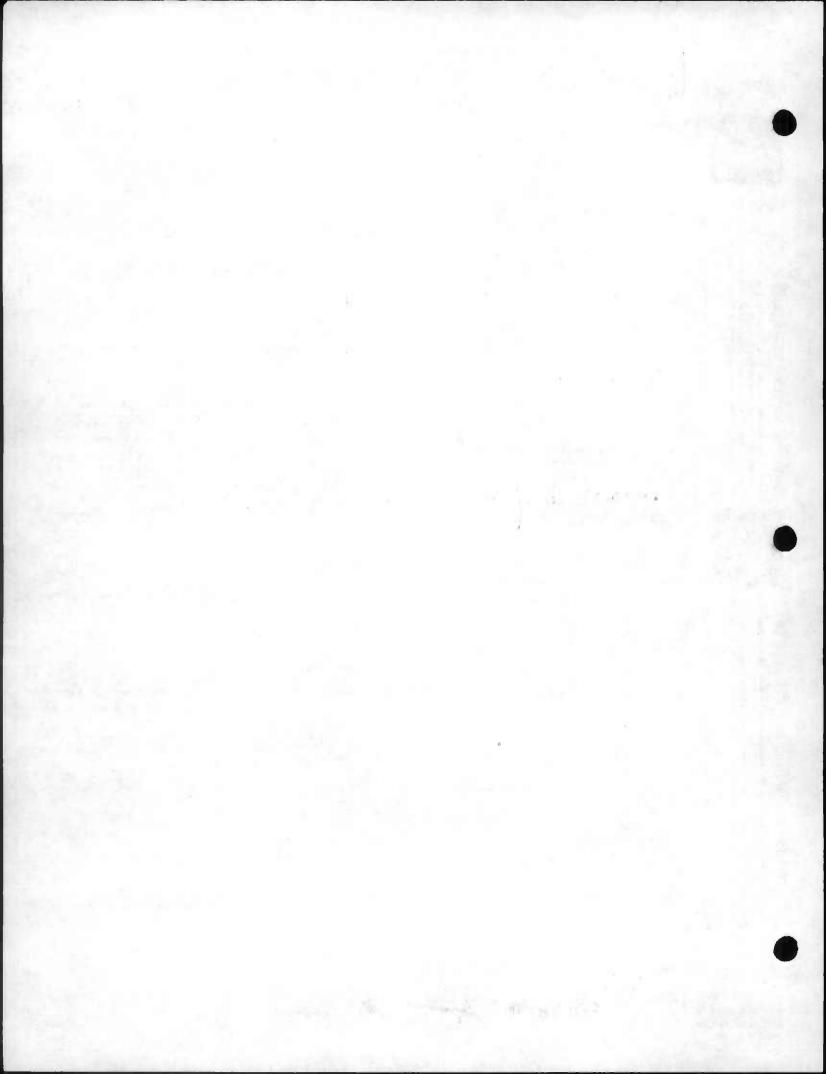
10 Burial 2 Cremation 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State Mount Olivet Cemetery, Feb. 9, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Md. hat caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, on each line. Su 21701 Approximete tnterval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ears for use as the burlet-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy tindings available prior to page 2 should 24e. Wes an autopsy performed? completion of causa of death? After this certificate has 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: funeral director. 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 9 28t. Location (Street and Number or Rural Route Number, City or Town, Stefe) 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 T Homicide

Division of Vital Records, P.O. s after death. To the Hospital owithin 24 hours at To the Funeral D completely

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Dete signed (Month, Day, Year) m D 00 18063 February 7, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 104 HOUSE 32. Registrar/Signeture

edical

State Registrar

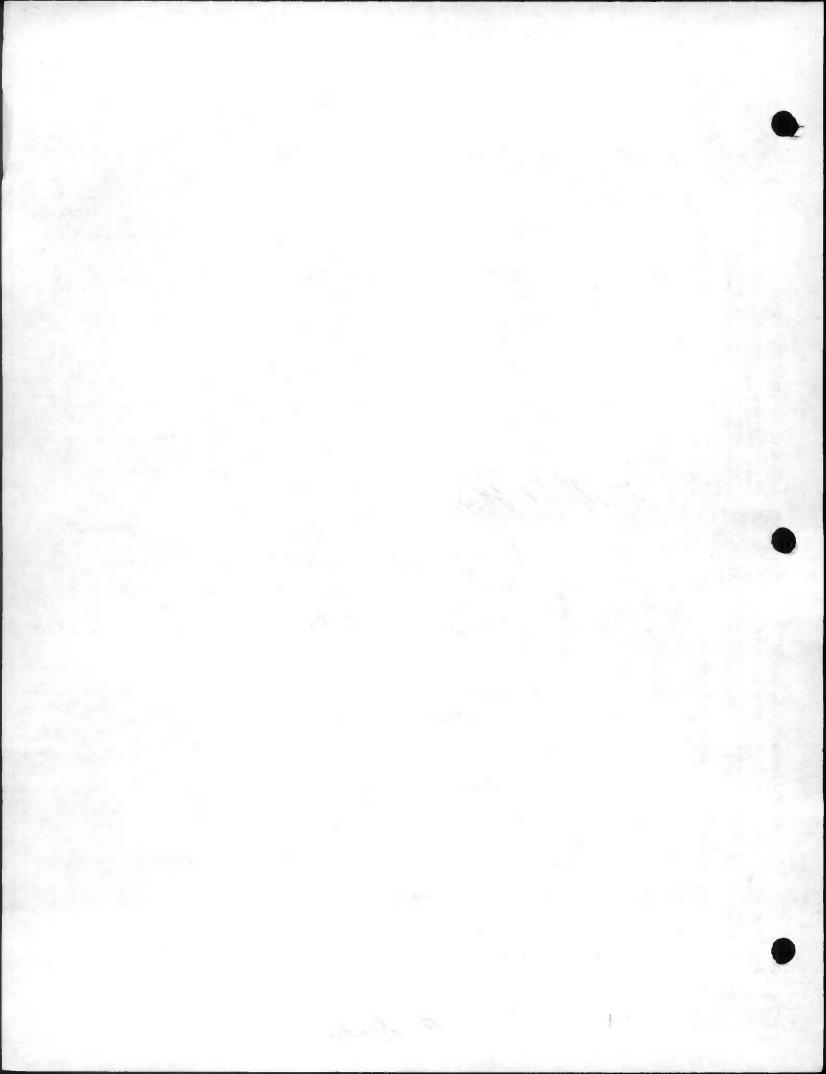


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Tima of Death February 10,2000 **Physician** OHLER 17:32 HARRIET VIRGINIA /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1□M 2QF 91 577 20 8944 Sept. 8, 1908 Director MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or flame 23s or 28a-f show with injury or other traumatic avant, the Medical Example must be notified at page. 10d. Inside City Limits Chesapeake Beach Calvert 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5007 Valley Drive 20732 USA Funeral 11. Maritat Status 12. Was Decedant Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yaa or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detas: 1 Nevar Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) homemaker 6 own home 17. Father's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surname) Henry Vincent Hoover Anna Mary Rowe 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn V. Ohler (husb.) same as 10 above 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) 2-14-00 Cedar Hill Cemetery Suitland, 21. Signature of Funaral Sarvice Lies 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** tmmediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Examiner attending physician and I for use as the burial-transit certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Acudent Box 68760 ere brovascula Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the causa of death? Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown 2 Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy eta has paga 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No this cartificata Division of VItai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification of the funeral director, it 25. Was casa referred to medical Be 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 10 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred edical Certification: 1 Matural 5 Pending Injury invastigetion 1 Yas 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie 29c. License number 2-11-00 312 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 8 Dr. Jonathan Lowenthal, M.D. Prince Frederick, MD 20678 31. Data filed (Month, Day, Year) 32. Registrer's Signatura FEB • 4 2000

Registrar

Spark



### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** February PABLO NIEVES ORTIZ /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 98 580-38-7117 Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Madical Examiner must be notified as Directo MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 403 PATRICK AVE. 21801 APT. B Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detes: "natural", or itema 11 Marital Status 1 Never Merried 2 Married 21215-0020 þ 3 Nidowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) filed within 7 Hygiene.

College (1-4or 5+)

CASTILLO- DAUGH.

CKTP

23a. Part1. Enter the disaasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

NIEVES

8. Data of Birth (Month, Day, Year) JAN. 13, 19 PUERTO 1902 RICO 10d. Inside City Limits Yes 2 No 10g. Citizen of What Country? U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 1 Yes 2 □ No Specify: PUERTO RICAN Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MAINTENANCE MUNICIPALITY 18 Mother's Name (First Middle, Maiden Sumama) ENCARNATION ORTIZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 403 PATRICK AVE. APT. B SALISBURY, MD 21801 20b. Place of Disposition (Name of cematery, cremetory or other place) Date 20c. Location - City or Town, Stete 2/17/00 SALINAS, PUERTO RICO MUNICIPAL de SALINAS 22. Name and Address of Facility 705 E. MAIN ST.

Month

Day

9

Year

WICOMICO

SALISBURY, MD 21804

23b. Did tobecco use contribute to the cause of death?

12000

4c. County of Death

3. Time of Death

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9. Birthplaca (Stata or Foreign

**Physician** /Medical Examiner

signed by t

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funeral

After

he Hospital or Attending P in 24 hours after death.

The Funeral Director: After the pletely filled in by the funeral

within 2 To the

certificate be executed

Box 68760

P.O.

Records.

Division of Vital

permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumetin.

B

W.

Nievesortiz

Baltimore, Maryland

Examine physician and the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Couse (Disaase or injury that initiated evants rasulting in death) Last edicai

Elementery/Secondary (0-12)

MARCELINO

20e. Mathod of Disposition

Immediate Ceuse (Finel disease or condition rasulting in death)

17. Fether's Neme (First Middle Last)

19a, Informant's Name/Ralationship (Type, Print)

1X Burial 2 Cremetion 3 Removal from Stata

Funeral-Service Licens

I.

4 ☐ Donation 5 ☐ Other (Specify)

ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each lina.	Approximata Interval Between Onset and Death
Bilateral roumania -72 w/g	2 diale
Cough tive Heart Failure -> 2 ~ 19	Layis
Tyshi Lephdant Diabetes Wellips	->20 m
Due to (or es e consequence of):	0
1	1

BOUNDS FUNERAL HOME, INC.

Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. py Completed 25. Wes case referred to medical axaminer? Be Hospital: 1 Inpatient Lo 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Yea Certification: 1 Neturel 5 Pending 2 Accident 6 Could not be

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a	a Disa	a	n C	BIC	24a. Was an a performed	17	24b. Ware autavailable completic of death?	prior to on of cause
	-1 - 1		20	6. Place of D	eath (Check only one)			
2[	ER/Outpatient	3□	DOA Other:	4 Nursing	Home 5 ☐ Residence	6   Oth	ner (Specify)	
r)	28b. Time of Injury	М	28c. Injury at Work? 1 🗆 Yes	2 □ No	28d. Describe how i	njury occur	rred	
At h	noma, ferm, stree	t, fact	ory, office	- 145	28f. Location (Stree City or Town, S	t and Numi tata)	ber or Rural Rout	e Number,

29a. Certifiar (Check only one)

3 Suicide

4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Day, Year) Fim St. Princess Anne, MD 21853

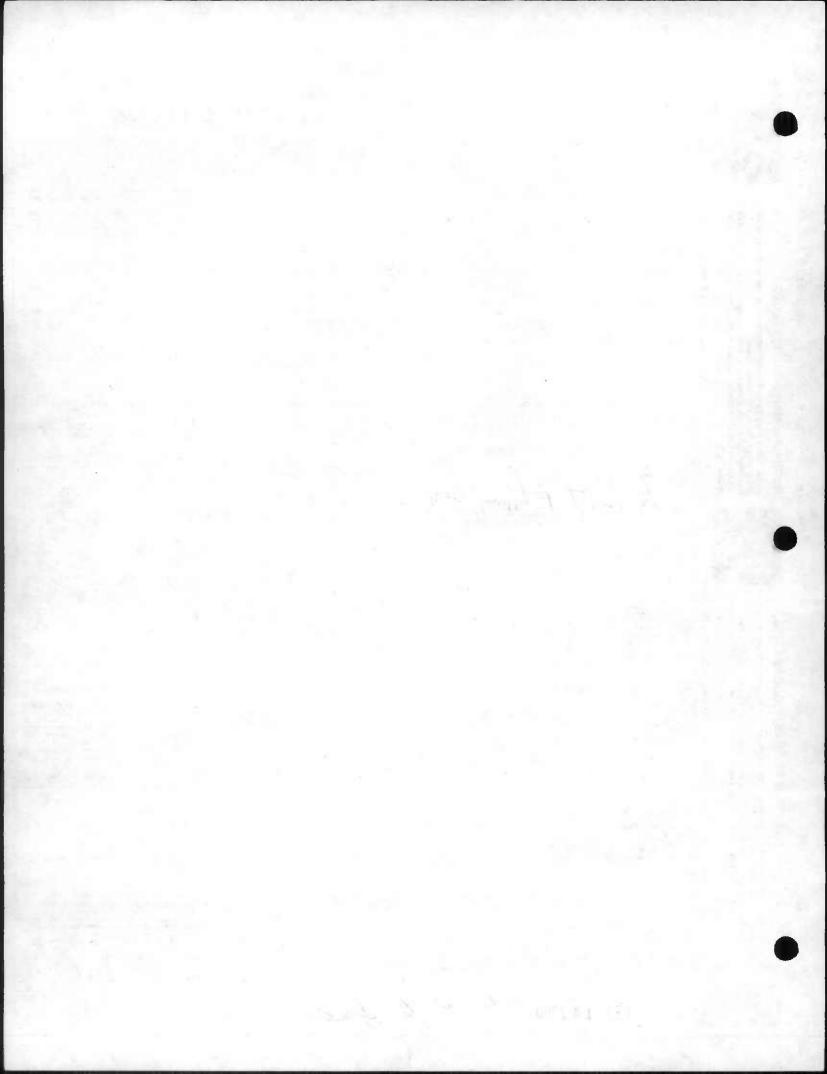
State Registrar

Medical

HAMIN 12137 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture FEB 14 2000

Neme and addrass of person who completed cause of death (Item 23a) (Type, Print)

28e. Plece of Injury - building, atc. (Sp.



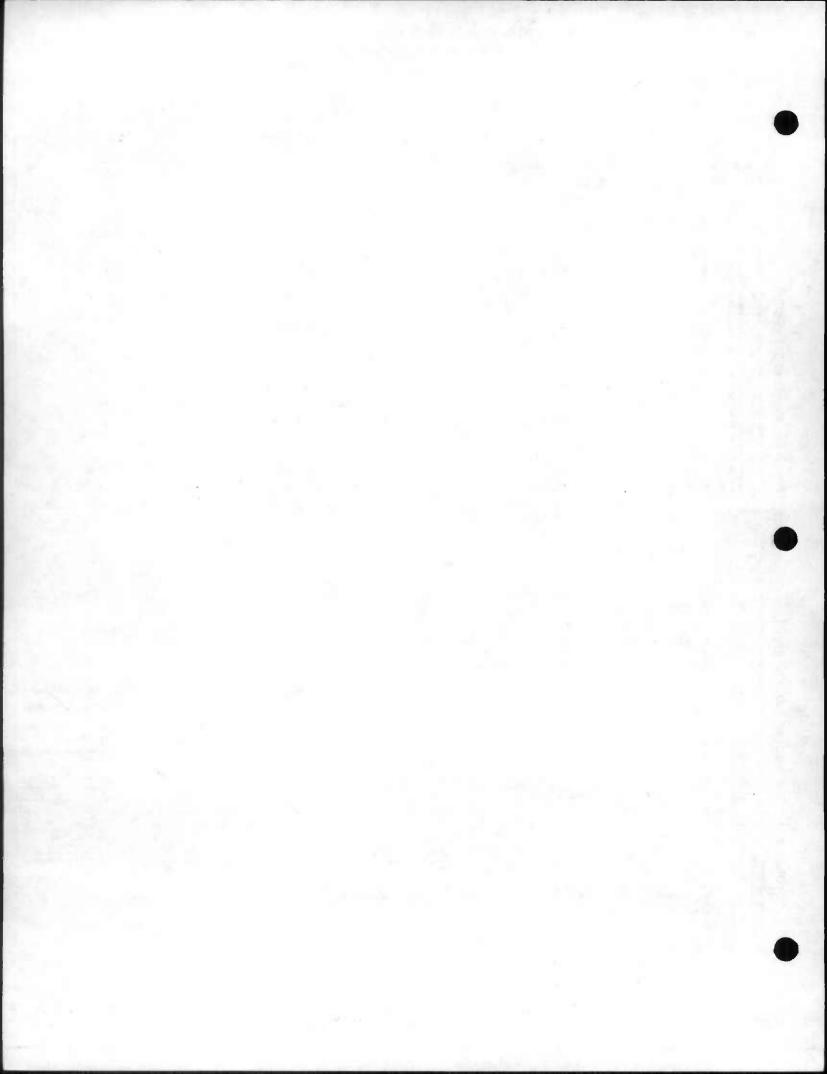
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** February 4, 2000 2:15 PM Sara Oakley /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Wicomico Salisbury Center: Genesis ElderCare Salisbury, MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF Yrs. 214-10-7055 90 Director April 16,1909 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits al Hygiene. other than "natural", or thems 23a or 28a-f show vant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Cloverdale St. 21804 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.
Instit if Hear 27 Is marked other than 'natural', or items 23 int; if Hear of the unmatic avant, the Medical Ear interments any or other traumatic avant, the Medical Ear interments. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Marviand 21215-0020 1 Yes 2 No Specify: Specify. P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be John R. Beasley Martha Parker 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charlotte O. Landon/Daughter 605 Homer St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or pnce. 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 2/9/00 Salisbury, MD 22. Name and Address of Fecility Holloway Funeral Home Professional 21. Signature of Funeral Service Licenses maosi Association 501 Snow Hill Rd., Salisbury, MD 21804 plampoor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1000 Examiner Due to (or as a consequence of): physician and the buriel-transit or Attanding Physician: The law requires that the death certificate be associated Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) USB BS Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Completed by Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certities compietaly (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D 29349 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 William H. Robins, 1104 Healthway Dr., M.D. Salisbury, MD 31. Date filed (Month, Day, Year) FEB 0 9

DHMH 16 Rev 6/95

State Registrar

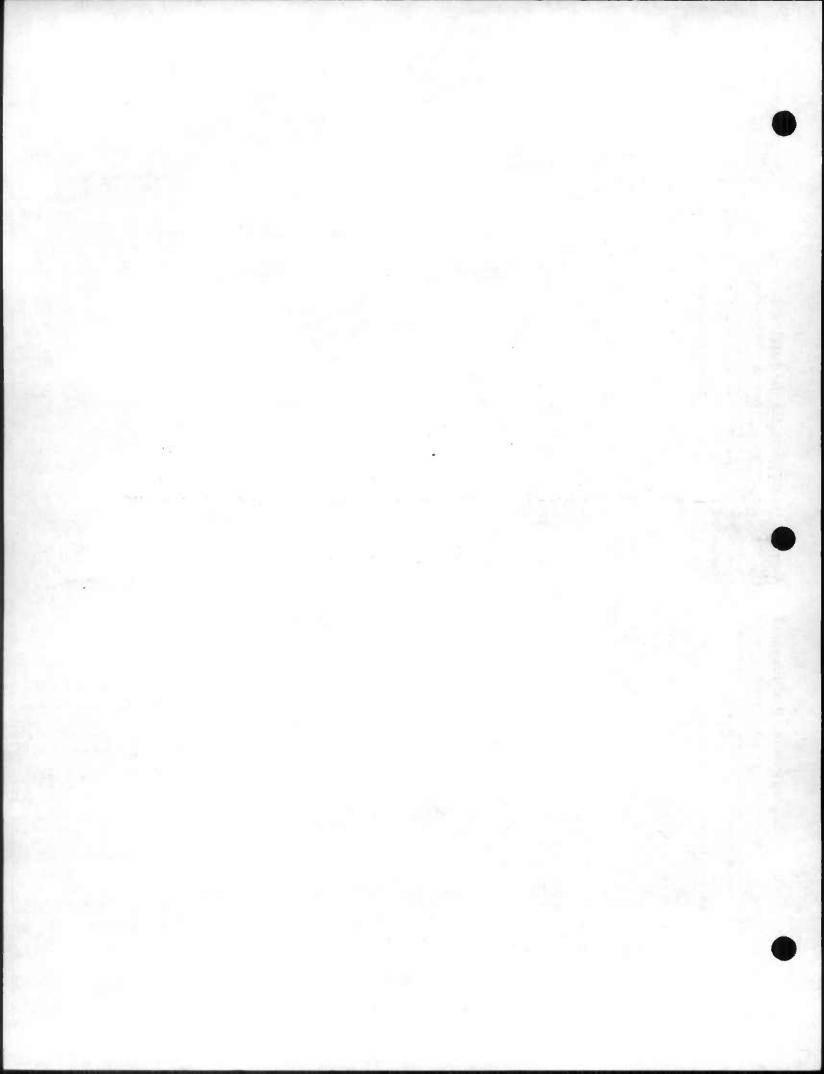
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death January 31, 2000 **Physician** Randall Pierce 3:07 P.M Henry /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick H Under 24 Hrs. 8. Data of Birth Hours Min. Aug. 1927 If Under 1 Year 5. Social Security Number 161-22-5043 7. Aga (In yrs. last birthday) 72 Yrs. Birtholaca (Stata or Foreign **Funeral** Months Days 1₩ 2□ F Perrysylvania Director Usual Rasidenca of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28 or 28s-f show any injury or other traumetic event, the Region Exeminer. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No **Funeral Director** Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 13306 Old Annapolis Road 21771 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc 1 ☐ Yas 2 XNo 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify Be Completed by 3 Nidowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Chemist U. S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Henry Ward Pierce Mabel Wright 19a. Informant's Name/Ralationship (Type, Print) Randall D. Pierce/Son 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13306 Old Annapolis Road, Mt. Airy, Md. 21771 20b. Place of Disposition (Nama of camatery, cramatory or other place)
Smithsburg Crematory 20a Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata Feb; Z, 2000 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice License 22. Nama and Addrass of Facility
Keeney and Basford Funeral Home M00021 106 East Church Street, Frederick, Md. 21701 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequanca of): P.O. Box 68760. Dua to (or as a consequence of) for use as been signed by the a should be detached t Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 1 No 1 ☐ Yas 2 ☐ No certificata 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatiant 2 PER/Outpatient 3□ DOA this 28b. Tima of tnjury 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding invastigation within 24 hours after death.

To the Funeral Director: All completaly filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarmined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiar and mannar stated. ş 29b. Signature and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. License number 20 D36610 February 2, 2000 30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print) Edward F. Fisher, M.D., 56 Thomas Johnson Drive, Frederick, Md. 21701

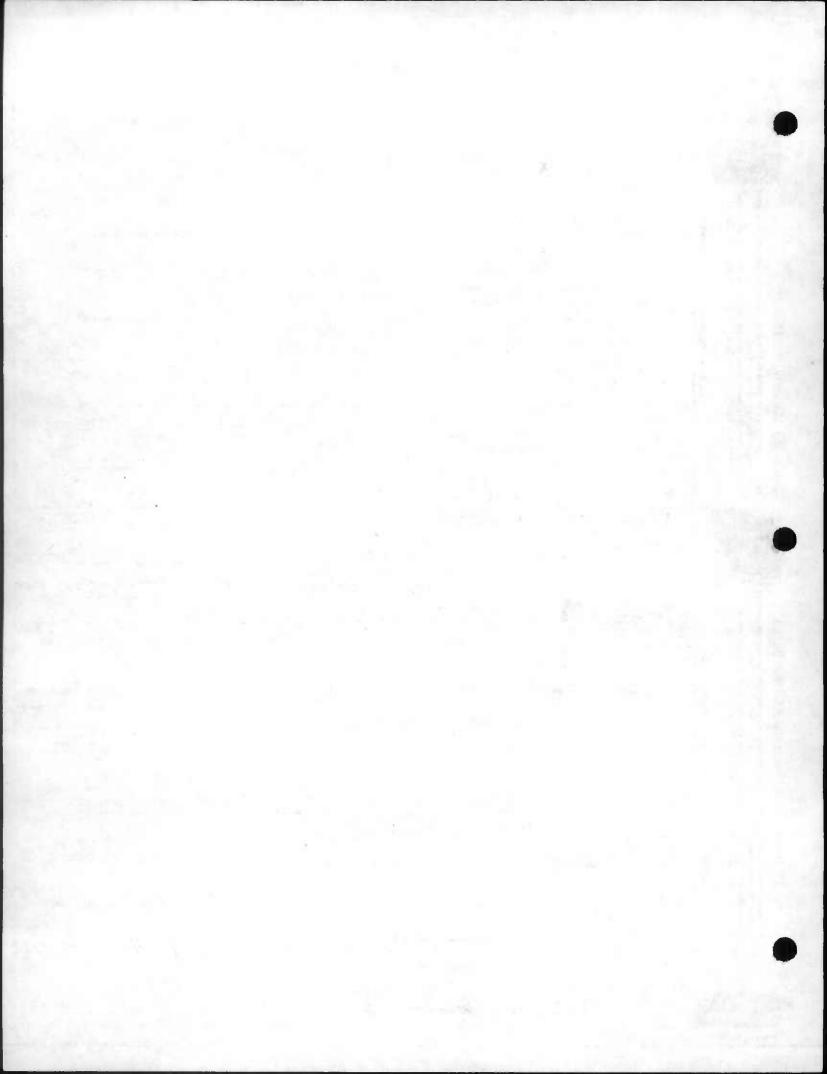
State Registrar 32. Registrar's Signatura



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

JOSEPH AL				2. Data of De		3. Time of Death
AL ALL	FRED PETR	20		JAN.	29,2000	7:10 am
4a Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Deal		
NORTHHAMPTON	MANOR NURSI	NG HOME	FRED	ERICK	FI	REDERICK
5. Social Security Number 6. Security 10	7. Age (In yrs. I	last birthday) If Unde Months	r 1 Year If Under 24 Hi Days Hours Mi		rth ny, Year) 12, 19	Birthplaca (Stata or Foraign Country)     O4 OHIO
Usual Residence of Decedent  10a. State 10b. County	100 Cib	y, Town or Location				40d Inside City I imite
						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
MD FREI	PERICK   F	REDERICK	p Code	1	10g. Citizen of W	
3536 Runkles I	rivo	101. 23	21770			
	12. Was Decedent Ever in U.	S. 13. Was Dece	dent of Hispanic Origin?	Specify Yes or N		- American Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	If Yes, spe	cify Cuban, Mexican, Pue 21XNo Specify:	rto Rican, atc.)		white, atc. WHITE
15. Decedent's Edu		16a. Decedent's Usu	al Occupation	odrina	16b. Kind of Bus	siness/Industry
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during most of wase retired)	UNITY	AUTO	INDUSTRY
	1 YR.	AUTO M	ECHANIC			
17. Father's Name (First, Middle, Last) PETER PETRO					, Maiden Sumame	B)
		1 am 11 m		N AMOS	- 02 =	O
19a. Informant's Name/Relationship (Ty			S (Street and Number or I		•	
BARBARA VISTIC  20a. Method of Disposition	20b. P	tace of Disposition (Na	ma of	MONRO		21770 City or Town, Stata
1 ☐ Burial 2 ☐ Cremation 3 ☐ R		emetery, crematory or ETRO CREM			BALT.	
4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	^		nd Address of Facility	2000	DALI.	MD.
Frang L.	Kollin	GARY	L. ROLLIN			
23a. Part1. Enter the disease, or compli shock, or heart fallum. List only or	cations that caused the death	n. Do not enter the mo	de of dying, such as cardi	ac or respiratory	arrest,	Approximata Interval Between
		n .				Onset and Death
Immediate Cause (Finat disease or condition resulting in death)		Desse	,		W.	01995.
resouring at Godding	Due to (or	as a consequence of)	7			11000 6 110
	- (	wille	secon ,	111111111	May med	11/1/2 1/1/2
Sequentially list conditions	Dye to (gr		/	10 1		(1793/00m
if any, leading to immediate	101111	ras a comequence of)	100 B	must	· ·	(1) of 10 or 10
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted events	mue	ras a coftaquerca of	not de	gaeste	a'	profits to was
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of)	not de	merte	a'	fronth,-year
that initiated events	Due to (or	as a consequence of	not de	merte	ia'	months-yea
Cause (Disease of Injury that initiated events resulting in death) Last						fronth, - yea
Cause (Disease of Injury that initiated events resulting in death) Last				23b. Did	tobacco use con	
Cause (Disease of Injury that initiated events resulting in death) Last				23b. Did	tobacco use con	tribute to the cause of death?
that initiated events				23b. Did	tobacco use con	tribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to
Cause (Disease of injury that initiated events resulting in death) Last				23b. Did	tobacco use con	tribute to the cause of death? 3 Probably 4 Unknow
Cause (Disease or injury that initiated events resulting in death) Last				23b. Did 1	tobacco use con	tribute to the cause of death? 3 Probably 4 Unknow.  24b. Were autopsy findings available prior to completion of cause
Cause (Disease of Injury that initiated events resulting in death) Last  Part II. Other significant conditions	Itributing to death but not resu		cause given in Part t.  26. Place of D	23b. Did 1	tobacco use con Yea 2 No s an autopsy ormed? Yas 2 No	tribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
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25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death   1   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   1   Natural   5   Pending investigation   6   Could not be determined   1   Natural   1   Natural   1   Natural   2   Accident   1   Natural   2   Accident   1   Natural   Natur	Inpatient 2  28a. Data of Injury (Month, Day Year)  28a. Place of Injury - At ho building, etc. (Specify	ER/Outpetient 3 D 28b. Time of Injury M	26. Place of D  OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No  y, office	23b. Did  1 □  24a. Was perfi  1 □  eath (Check only)  Home 5 □ Res  28d. Describe  28f. Location  City or To	tobacco use con Yea 2 No s an autopsy ormed? Yas 2 No one) idence 6 Otha how injury occurre (Street and Number win, State)	tribute to the cause of death?  3 Probably 4 Unknow.  24b. Were autopsy findings available prior to completion of cause of death?  1 Yas 2 No  ar (Specify)  ar or Rural Route Number,
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25. Was case referred to medical examiner?  1   Natural   S   Pending investigation   27. Manner of Death   S   Pending investigation   3   Suicide   4   Homicide   Physical Examiner   29a. Certifier (Check only only 10   10   10   10   10   10   10   10	Inpatient 2 28a. Data of Injury (Month, Day Year)  28a. Place of Injury - At ho building, etc. (Specify inclam: To the best of my known: On the basis of examinat	ER/Outpatient 3 D D 28b. Time of Injury M ma, farm, street, factor ) wedge, death occurred ion and/or investigation	26. Place of DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office	23b. Did  1 □  24a. Was perf  1 □  eath (Check only)  Home 5 □ Res  28d. Describe  28f. Location City or To	tobacco use con Yea 2 No s an autopsy ormed?  Yas 2 No one) idence 6 Otha how injury occurre (Street and Number win, State)  cause(s) and mar date and place, a	tribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yas 2 No  ar (Specify)  ar or Rural Route Number,  nner as stated.  Indiduct to tha cause(s)
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Part II. Other eignificant conditions condit	Inpatient 2 28a. Data of Injury (Month, Day Year)  28a. Place of Injury - At ho building, etc. (Specify and manner stated.	ER/Outpatient 3 D 28b. Time of Injury M Ima, farm, street, factor D Wedge, death occurred ion and/or investigation  29  23a) (Type Print)	26. Place of D OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No y, office at the time, date and plan, in my opinion, death occ.	23b. Did  1	tobacco use com  Yea 2 No  s an autopsy ormed?  Yas 2 No  one)  idence 6 □Othe how injury occurre  (Street and Number wm, State)  cause(s) and mar date and place, a	tribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  ar (Specify)  and  ar or Rural Route Number,  nner as stated.  Ind due to the cause(s)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5, George Randa11 Popolaski February 4:15 AM 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 215-54-9577 Director 21, 1952 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Directo r 28a-f Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 10537 Bethesda Church Road flerns 23a 20872 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Electrician 18 Mother's Name (First Middle Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 ahould be fit trainers of Health and Mental H tant. If Item 27 is marked off jury or other traumatic even 8 Anthony Andrew Popolaski Ida Ellen Randa11 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10537 Bethesda Church Road, Damascus, Maryland 20872 cs of Disposition (Name of Date 20c. Location - City or Town, State Robin D. Popolaski - Wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 Burial 2 Cremation 3 Removel from Stete 2/08/2000 Rockville, Maryland Parklawn Memorial Park 4 ☐ Donatie 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name and Address of Fecility Olin L. Molesworth P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or freat failure. List only one cause on each line. Damascus, Maryland 20872 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Myocardial Infarction Minutes Examiner Due to (or as e consequence of): Examiner Hypertension Years sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician the burial Box 68760 Physician/Medical Due to (or es a consequence of): 98 use P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed page 2 s has 1 Yes 2 No 1 Yes 2Q'No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 250No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Natural death. 1 Tes 2 No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled In Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only within 2 one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) vill 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Delouran Sherm: 11 m.a. 901 Medical

**DHMH 16 Rev 6/95** 

State

Registrar

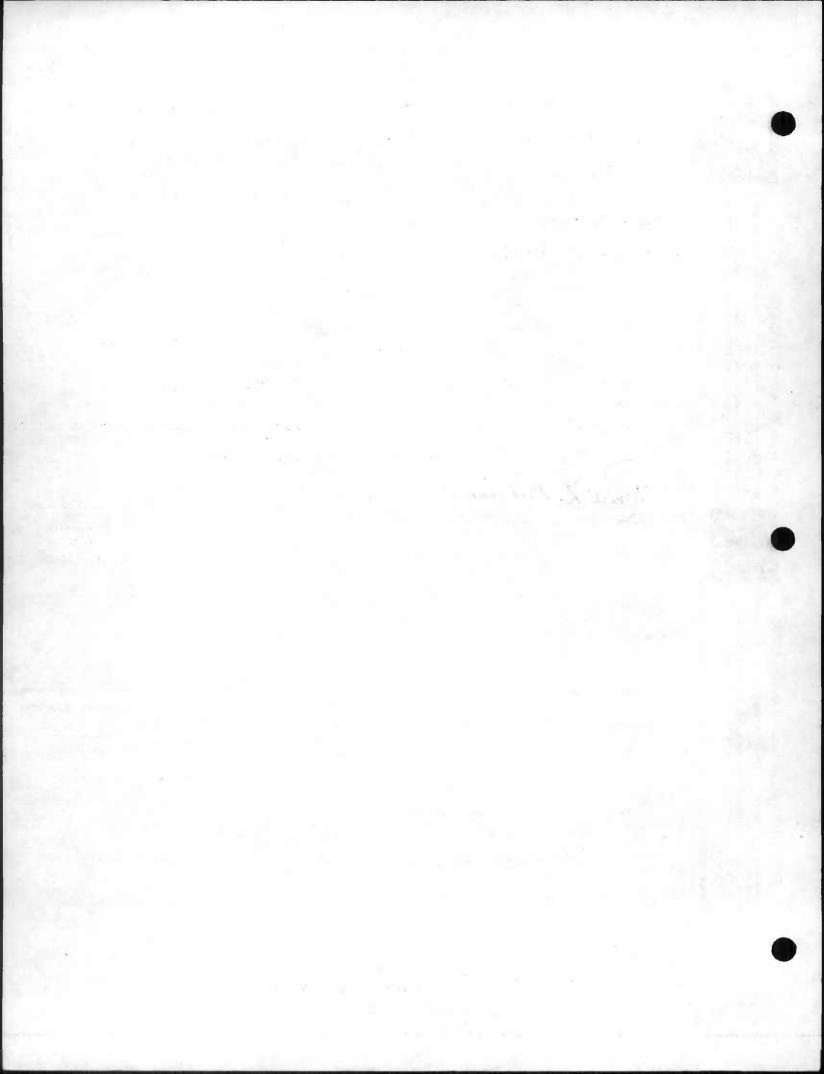
31. Dete filed (Month, Day, Year)

32. Registriv i Signeture

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Center Dr. Rockville, mp. 20 850



### Piease Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Feb 12, 4b. City, Town, or Location of Death Donna Lynn Petty 2:15 AM 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Solomons ar If Under 24 Hrs. Harbor Island Marina Slip 35 Calvert 8. Date of Birth (Month, Dey, Year) 9. Birthplect Country) Aug 1, 1958 Washington DC If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2□F Months Deys Hours Min 41 Yrs Director 214 78 1474 Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Calvert Solomons 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with Harbor Island Marina Slip 35 20688 United States death Funer 12. Wes Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after can of Health and Mantal Hygiene. Int: If fam 27 Is marked other than "natural", or iter INY of other traumalic event, I'm Medical Enaturals. INY of other traumalic event, I'm Medical Enaturals. 1 Yes 2 No if Yes, Give X Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 Widowed 4 Divorcad white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) own home 11th homemaker 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Alred Jerry Dixon Marquess Lillian Iona 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) George Petty- husband same as #10 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 16 2000 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Feb permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA Brauck 4405 Broomes Is. Port Republic MD 2067 rd. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Syndrone /Medical Immediete Cause (Finel Lylars diseese or conditio resulting in death) Examiner Due to (or es e consequence of) Examiner physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): certificata be axec P.O. Box 68760. Physician/Medical Due to (or es e consequenca of) SB USB 0 signed by the a 23b. Did tobacco usa contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 XNo 3 Probably 4 Unknown Division of Vital Records. P 24b. Were autopsy findings available prior to Completed 24e. Was en eutopsy completion of cause of deeth? page 2 has 1 Tyes 2 No cartificata 1 Yes 2 BONG 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4□ Nursing Home SE Residenca 6 □ Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Aftar or Attending Neturel 5 ☐ Pending after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital TEL Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune complately fi edicai (Check only one) 29d. Dete signed (Month. Day, Year) 29c. License number 29b. Signeture end title of certifier D 46314 Feb 14, 2000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

**DHMH 16 Rav 6/95** 

FEB 4 2000

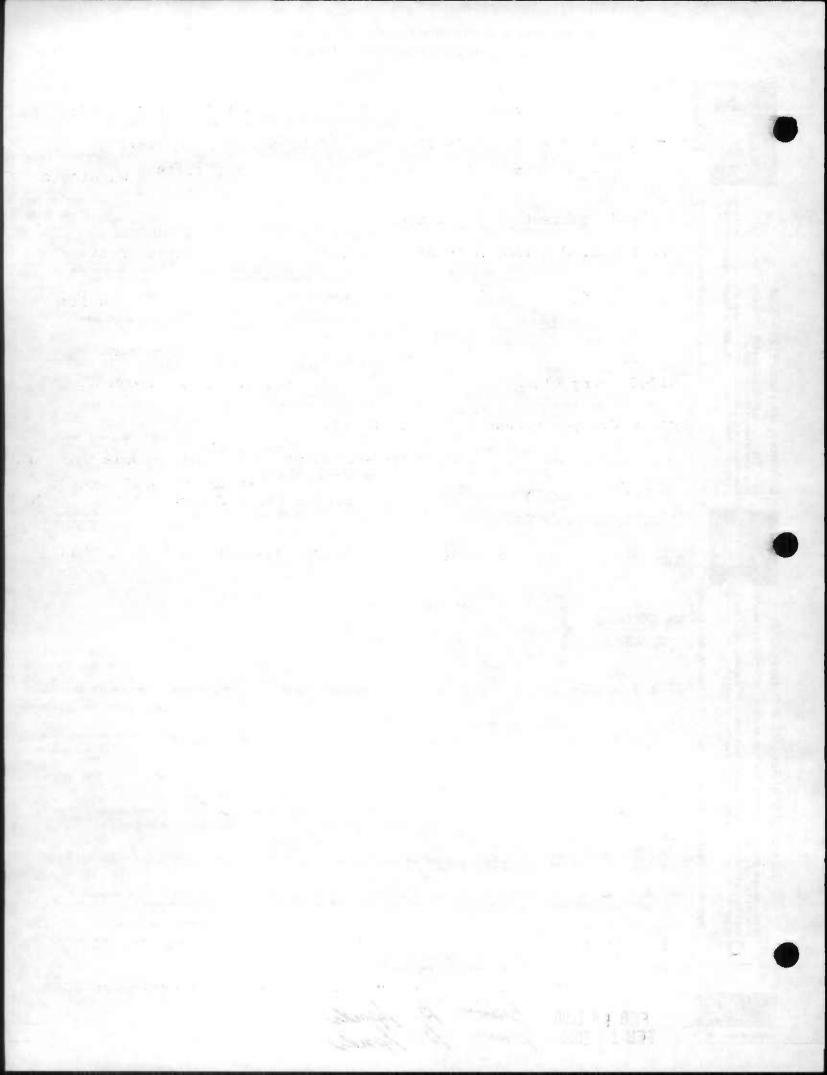
Paul V.

31. Dete filed (Month, Day, Year)

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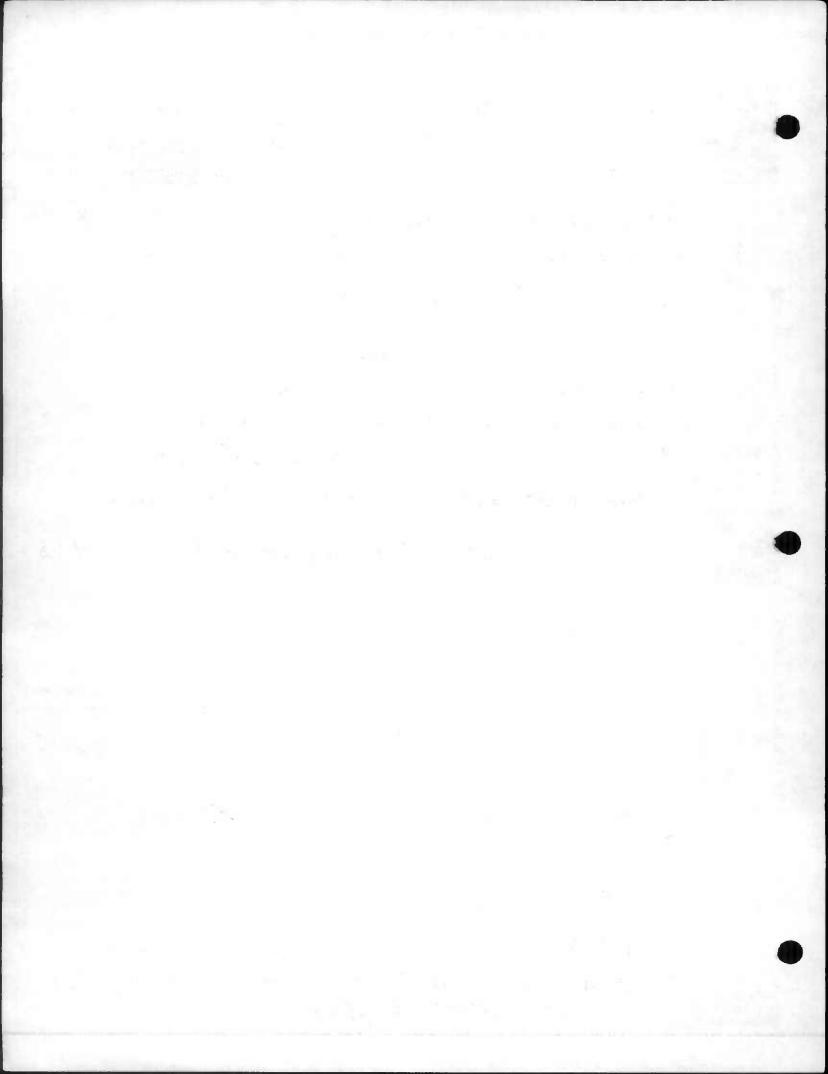
Pomilla, 110 Hospital Rd. Prince Frederick, MD 20678 32. Registrer's Signeture 20,0

M.D.



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			1. Decedent's Neme (First, Middle, Las	t)					2. Dete of Dee			3. Time of Death
	Physici /Medi Exami	cal	James Edward  4e. Fecllity Neme (If not institution, give	Purnell street and number)	JR.			4b. City, Town, or L	Month Februa	ry 9 2	Yesr 2000 of Deeth	3:03 PM
7	LAGITI		139 Second Str	eet				Salisbu	rv	Wicon	nico	
	Funeral Director		5. Social Security Number 6. Se 143-22-0794		e (In yrs. las	Yrs. If Un	der 1 Yea hs Deys	r If Under 24 Hrs.	8. Dete of Birth (Month, Dey June 3	Year)		ce (State or Foreign y) ersey
Marylend	f show	٥٠	Usuel Residence of Decedent  10e. State 10b. County  Maryland Wicom	igo		Town or Location	1				100	d. Inside City Limits  1 Yes 2 No
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h with	38 0		139 Second Str	eet			2180	1		U.S.A		
d 21215-0020 filed within 72 hours after death with the Marylend	if Health and Mentel Hyglene. Item 27 is marked other than "natural", or items 23s or 28s–1 show other traumstic event, the Medical Engineer must be notified at	by Funeral	11. Meritel Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:	10	13. Wes De		Hispenic Origin? (Sp ben, Mexican, Puerto	pecify Yes or No- Dicen, etc.)	14. Rac	e - Americer ck, White, et	c.
Maryland 21215-0020 d 2 should be filed within 72 hours af	e. an "nature Medical E	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)	ucetion		16e. Decedent's L	Isuel Occu work done T use retir	upetion e during most of work ed)	king	16b. Kind of Bo		
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Mar 12 sh	Is m		19e. Informent's Name/Reletionship (T					et end Number or Ru				Code)
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/I Ex	ysician Medical caminer	ner	shock, or heart failure. List only of Immediete Cause (Finel disease or condition resulting in death)	· m	tas	tatte es e consequence	of):	ny Cor	mu			ntervel Between Onset end Deeth
55/5U, ficete be executed	physician and s the burial-trensit	dical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest	C		es e consequence						
BOX 6	D) (6	Physician/Med		d								
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that the de	ned by the detache	by Phy							DC.	/es 2□ No	3 Proba	ably 4 □ Unknown
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	pa	Con							1 □ Y	es 2 No	10	Yes 2□ No
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DIVISION Of VITA	h. After this certificate has funeral director, page 2	tion: To	1 Yes 2 No  27. Manner of Deeth  102 Naturel 5 Pending 2 Accident investigation	1 Inpatie 28e. Dete of Injur (Month, De)	y. 2	R/Outpetient 3  8b. Time of Injury	28c. Inj		ome 5 Resid 28d. Describe h			
DIVISI	s efter deatl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.		e, ferm, street, fed	tory, office	Э	28f. Location (S City or Tow	treet end Numb n, State)	per or Rurel I	Route Number,
Hospit	within 24 hours efter To the Funeral Dire completely filled in b	edical	29e. Certifier (Check only one) Certifying Phy	sician: To the best of iner: On the basis of end menner sta	exemination	edge, deeth occur n end/or Investige(	ed et the tion, in my	time, dete end plece opinion, death occur	, end due to the c rred et the time, c	euse(s) end me late end plece,	enner es stel end due to t	ted. he ceuse(s)
Toth	To the	Me	29b. Signaturi and Haller of certifier	0	hints or		29c. Licer	nse number	,	29d. Date signe	d (Month, Di	ey, Yeer)
	4		- A C	ompleted ceuse of de		(3e) (Type, Print)	0 /	0007	CV	717	100	MM
	Sta	ite	31. Dete filed (Month, Day, Year)	32. Regisfre	er's Signetur	t.	WR	ROLL ST	34	USEV	lay	111
	Registr	ar	FEB 142	000	Port	p.	ppa	us/				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HELEN FEBRUARY 05, 2000 LOMAX PEYTON 6:40 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION CENTER WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year Months Days 6. Sex 1 ☐ M 2 ☐ F 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 96 Director OCT. 13, 1903 D.C. 579-42-7470 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND WORCESTER OCEAN CITY 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 BALTIMORE AVENUE 21842 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.

Int: If Hean 27 le marked other than "natural", or hema 23 my or other treumatic event, the Wedles Empirier mainty or other treumatic event, the Wedles Empirier mainty or other treumatic event, the Wedles Empirier mainty or other treumatic event, the Wedles 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 FEDERAL GOVERNMENT FORM DESIGNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 HORACE PEYTON HATTIE CROUCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 BALTIMORE AVE., OCEAN CITY, MARYLAND 21842 SARA A. WEISMILLER/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If eny Injury or pages. 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 2/8/00 BRENTWOOD, MARYLAND 21. Signature of Juneral Service Licensee 22. Name end Address of Facility the HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. Approximete Interval Between Onset and Death **Physician** A cute myounding Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial ateniosche 16511 Physician/Medical Due to (or as a consequence of) 180 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VINIM DISTASE Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) To Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours efter deal To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number Feb-6-2000 D02026

State Registrar

DHMH 16 Rev 6/95

the Manyland

PEYTON.

Baltimore, Maryland

The law requires that the death certificate be executed

certificate

After this

death.

To the Hospital

Box 68760.

P.O.

Records.

Division of Vital or Attending Physicien:

46 TEAL CIRCLE, BERLIN, MD 21811

410-641-4400

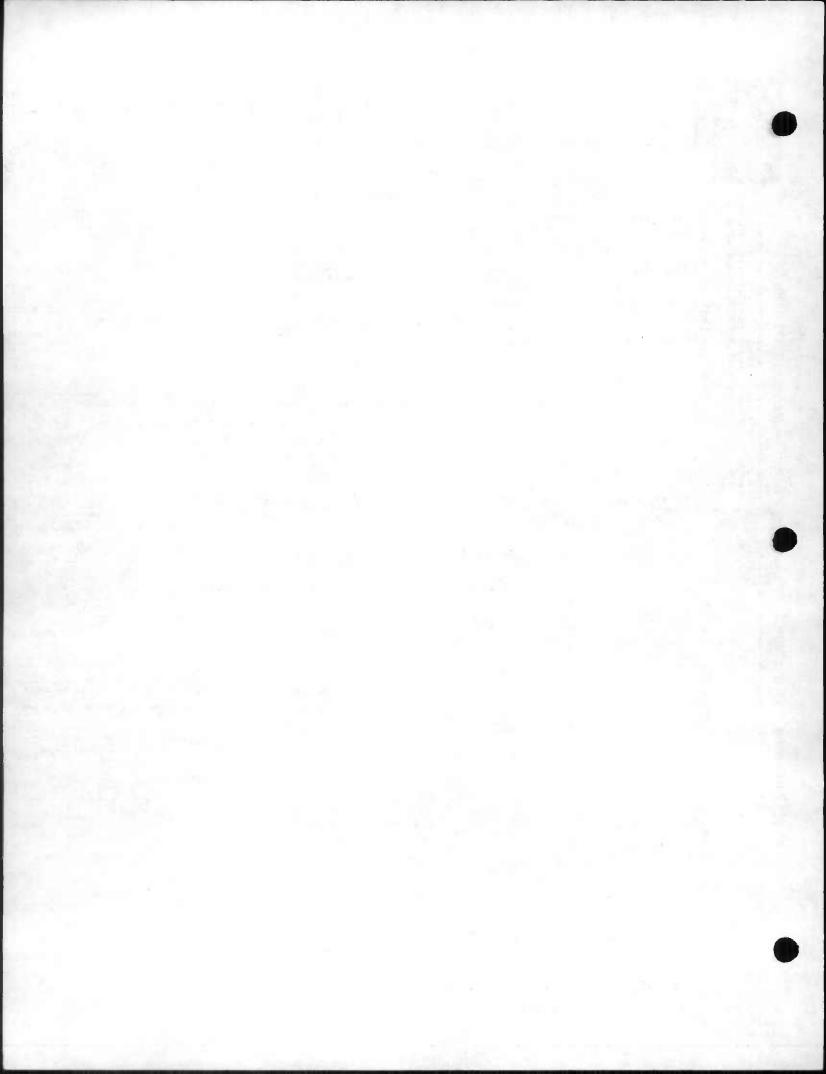
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

32. Registrar's Signature

DR. FEDERICO ARTHES,

31. Date filed (Month)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **EDISON** HAROLD PULLIN February 8, 2000 2:30 P.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Lorien Riverside Nursing & Rehab. Center Belcamp Harford Hours Min. 8. Date of Birth (Month, Day, Year) June 6, 1930 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Months Days 69 Maryland 213-24-5791 Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnslde City Limits 1 Yes XXNo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Charlestown Drive 21040 USA 12. Was Decedent Ever In U,S. Armed Forces? PETYES 2 □ No If Yes, Give Year or Dates:1951-54 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dye Cutter Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Wilbur Bertha Dilfer Empson Pullin Leona 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Eddie L. Pullin - Son 1305 Charlestown Dr., Edgewood, Maryland 21040 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Daugal 2 Cremation 3 Removal from State 5 ☐ Other (Boe Dublin Missionary Baptist 2/11/00 Darlington, Maryland re of Funeral S 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD at ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.

21. Sion Physician

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examinar must be notified at

Baltimore, Maryland 21215-0020

mmit. Pages 1 and 2 should be filed within 72 partners of Health and Mantal Hygiana. Vortant if flem 27 is marked other than "nath injury or other traumests.

/Medical

Examiner

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physician es the burial

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P

Completed

Certification: To

cai

P.O.

Division of Vital Records.

Physician/Medical

Immediate Cause (Final

disease or condition resulting in death)

Cong (

Approximate Interval Between Onset and Death dy cars

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequenca of):

Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death?

Transitional cell concinous of the Bladde,

1 Yee 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Metabolic encephalopathy

1 Yes 20 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1□ Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) investigation

Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

29a. Certifier

Natural

€ □ Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

5 Pending

6 Coutd not be determined

29d. Date signed (Month, Dev. Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

541

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After the completaly filled in by the funeral

30. Name and address of person who col eted cause of death (Item 23a) (Type, Print) un

rd Bel Air MD 21014

Registrar

31. Date filed (Month, Day, Yeer) 32/Registrar's Signature FEB 1 0 2000

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nuo

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Mag Arthur 1871 grade agree of the same of the 

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dev . Month Year MINNIE EVELYN PERDUE 4b. City, Town, or Location of Death 1 4c. County of Death 0708 4e Facility Neme (If not institution, giva street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Date of Birth (Month, Dey, Year) JAN. 15,1906 If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Deys 10 M 2 F Months Hours Country) MARYLAND 216-48-7402 94 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MARYLAND WICOMICO PARSONSBURG 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21849 U.S.A. 32786 POWELL ST. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Nevar Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE Yaar or Dates: 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumems) AUSTIN PARSONS ANNIE ALLEN 19e. fnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. EDWARD WARREN - SON 32786 POWELL ST. PARSONSBURG, MD 21849 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete JERUSALEM CEMETERY 2/4/00 PARSONSBURG, MD 4 ☐ Donetion 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. S 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. SALISBURY, MD 21804 Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of): Mar edune Due to (or as a consequence of): hoschopie Dua to (or es e consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed?

**Physician** /Medical Examiner

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signed

page 2 certificata

director.

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Department of Health and Mental reportant: If Item 27 is marked o

Pages 1 and 2 should

**Physician** 

/Medical

**Examiner** 

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Certification:

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**Funeral** 

Director

show.

25a-1

must be

'natural', or flams 23a or

21215-0020

altimore, Maryland

J

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was case referred to medical

1 Yes 2 No

26 Place of Death (Check only one)

1 ∏Yes 2 ∏ No

29d. Date signed (Month, Day, Year)

examiner?	Hospitel: 1 Propatient 2	ER/Outpatient 3	DOA	Other: 4 Nur	sing Home 5 Residence 6 Other (Specify)
27. Menner of Death  1. Naturel 5 Pending 2 Accident investige	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. I	njuryat Nork? I□Yes 2□N	28d. Describe how injury occurred
3 Suicide 6 Could no determin		ome, ferm, street, f	fectory, offi	СӨ	28f. Location (Street end Number or Rural Route Number City or Town, Stete)

29e. Certifie (Check only one)

Lan

Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted.

29c. Licensa number

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Kaap mo

00 Shore Drive Salisbury MO 2180

12+5

29b. Signeture end title of cartifier

32. Registrer's Signeture

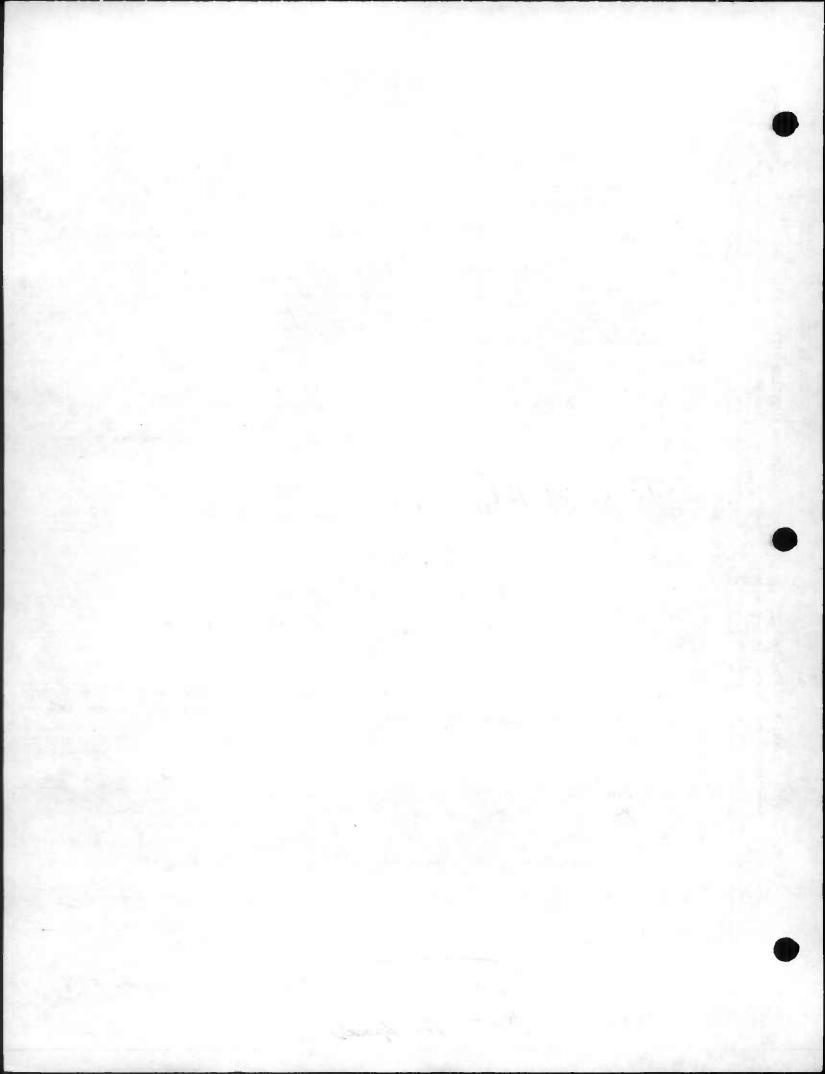
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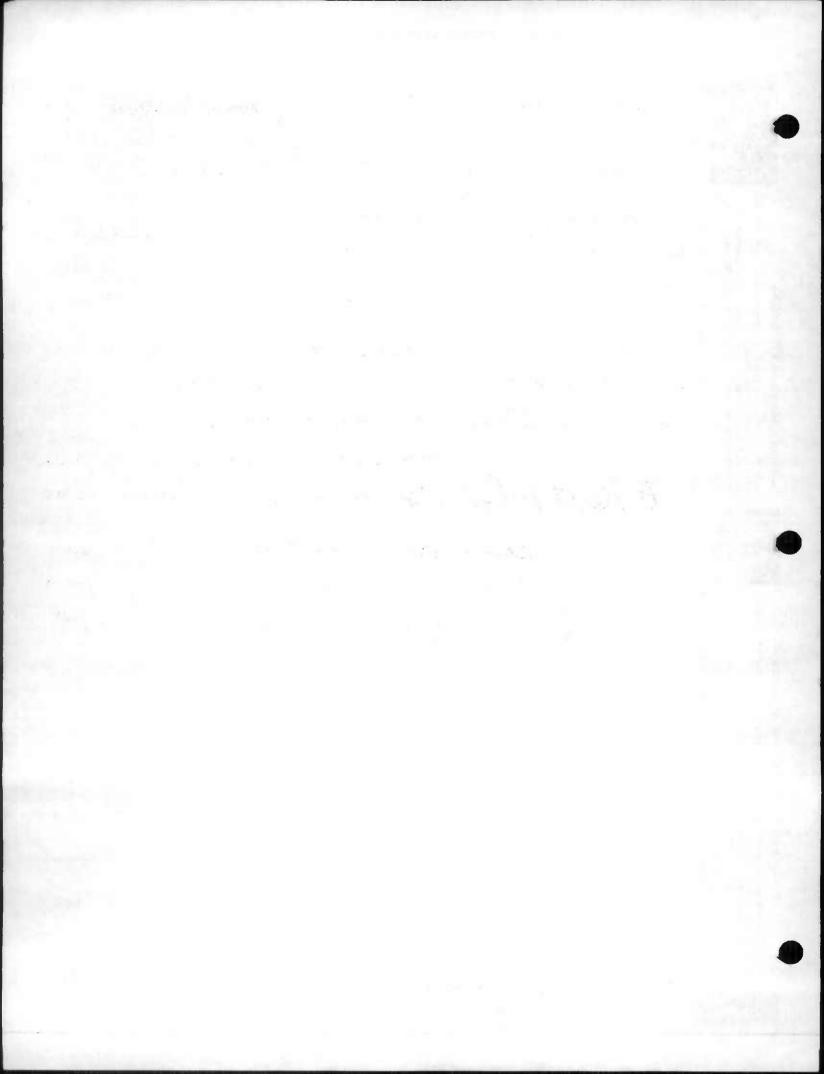
> State Registrar

**DHMH 16 Rev 6/95** 

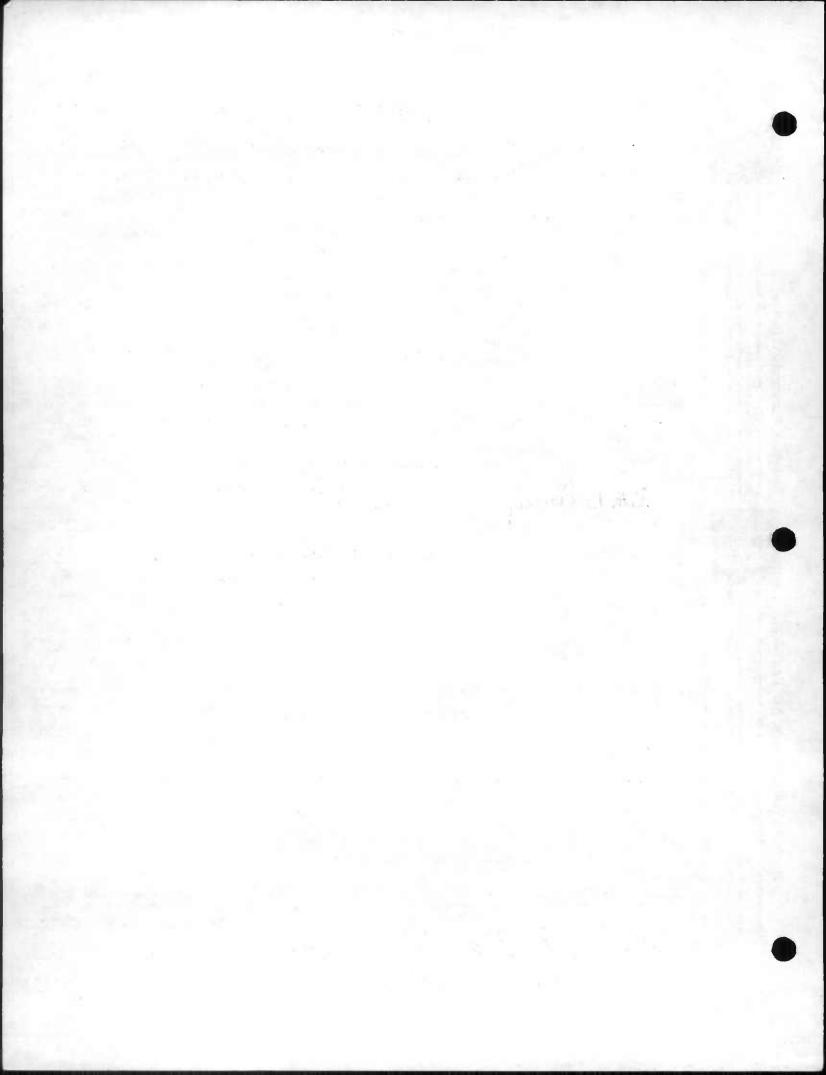


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To the Hospital or Attending Phy within 24 hours aftar death. To the Funeral Director: Aftar thi complataly filled in by tha funaral		29a. Certifier 17 Certifyin	g Phyalcian: To th	e best of my kno	owledge deeth	occurred at the tir	me dete end plac	e and due to the	ceuse(s) and mu	enner es st	eted
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0.		31. Dete filed (Month, Day, Yeer)	) 500	Begistrer's Sign	ature /	snu	com	July			0,0
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DHMH 16 Rev 6/95



				of Maryla	Ce	rtificat	e of l	Death		Reg. No.		
Physician	1. Decedent's Nemo	e (First, Middle,	Last)						2. Date of Dea Month	ath Day	Year 3. Ti	me of Death
/Medical	CLEO		L		PIOT	ROWSK:			Januar			7:15 ar
Examiner	4a Facility Neme (I	f not institution,	give street and n	umber)				lb. City, Town, or L	ocation of Death	4c. Coun	ty of Death	
ral	WICOMICO  5. Social Security N		g Home S. Sex	7 Ann //n .um	. last birthday)	If Under	1 Year	Salishur	9 Date of Bird		comico	tota as Casaian
	230-46-6		1 □ M 2 🛱 F		Yrs.	Months	Days	Hours Min.	(Month, Da		9. Birthplace (S Country)	
1	Usual Residence of			62					June	14,1937	Virgini	a
	10s. State	10b. County		10c. C	ity, Town or Le	ocation					10d. Insi	de City Limits
5	Maryland	Wicc	mico	- 5	Salsibu	ry					1 🛚	Yes 2 No
	10e. Street and Nur	mber				10f. Zip	Code			10g. Citizen o	What Country?	
	6135 Wes	stbrook	e Drive				2180	01		USA		
	11. Marital Status		12. Was Dec Armed F	cedent Ever in Corces?	J,S. 13.	Wes Dece	dent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	ace - American Indi	an,
ı	1 Never Merri		If Yes, G	2 X No		1 Yes		Specify:		Spec	ihr:	
ŀ	3 🔀 Widowed		Year or	Dates:		1 41 14	10				White	
	(Spec	15. Decedent's city only highest	grade completed	)	(Give	dent's Usu kind of wo DO NOT u	rk done d	during most of work	ing	16b. Kind of	Business/Industry	
	Elementary/Seco	indary (0-12)	College	(1-40/ 5+)			JO 7011100	,		Food	Service	
Ì	17. Father's Neme	(First, Middle, L	nst)	10 V - 1 W	wall	ress		18. Mother's Nem	e (First, Middle,			
	Hazel Re	eed						Eliza	beth Se	xton		
	19a. Informant's Na	ame/Relationshi	p (Type, Print)		19b. Maili	ng Address	(Street	and Number or Rui	al Route Numbe	er, City or Tow	n, State, Zip Code)	
	Theodor	e Stanle	ey Piotr	owski/S	on (	5135	West	orooke Dr	., Sali	sbury,	MD 21801	
ľ	20a. Method of Disp			20b.	Place of Dispo cemetery, cre	osition (Name	ne of ther plac	ne)	Date	20c. Location	- City or Town, Ste	ete
l		Cremetion 3     Specific Speci	B □Removel from acify)	1 State	lisbur				/28/00	Sali	sbury, MD	
Ì	21. Signature of Fu	meral Service Li	censee		2:	2. Neme ar	d Addres	ss of Facility		V X		
	D 26. #	P D	CTT = -A.D.								nal Assoc	iation
	23a. Part 1. Enter th	he disease, or c	omplications that	caused the dea	ith. Do not en	ler the mod	ie of dyin	Hill Rd., g, such as cardiac	or respiratory a	mest,	Appro	ximate
	SHOCK, OF Heal	it lenure. List or	nly one causelon	eech line.				0			Onset	end Death
	Immediate Cause (	(Finel	(0	escin	ome	at	1	una	with	Real	4	mos
	resulting in death)		8	Due to	or as a conse	quence of):	95	2000	4:		1	W. FO
			- h			-	9	ucas	Tuze	,		
	Sequentially list con	nditions,		Due to	or es a conse	quence of):						
I	if any, leading to im cause. Enter Unde Cause (Disease or	injury	C									
800	that initiated events rasulting in death) L			Due to (	or as a consec	juence of):						
			d		200							
5												
	Part II. Other signifi	icant condition	s contributing to	1		nderlying o	ause giv	en in Part I.		100.000	contribute to the co	Service Sintillines
1	vaner	mon	ua.	Vrak	Beles	M	ell	elus	10	Yes 2□ No	3 □ Probably	4)K) Unknow
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	1	11 (1	oron	ary (	like	ry	lu	rease	perfo	rmed?	available completic of death?	n of cause
	Type	4		/		/					Oi Godiiii	
	Type	-10	000		,0	1	, ,		40)	va ottala	4 🗆 Vee	OCI No.
	Type	pher	el V.	ascu	lar	I	èse	are	10	74	1 ☐ Yes	2 No
	25. Wes case Indiana.		Hospital:	asen	lar	I	Oth	26. Place of Deal	th (Check only o	one)		2 No
	25. Wes case more examiner?  1 Yes 25.  27. Manner of Death	No	1	Inpatient 2[	Car ER/Outpatie			er: 4월 Nursing H		one) dence 6 C	ther (Specify)	2 No
	examiner? 1 Yes 25  27. Manner of Death 1 Natural	No	28a. Dete	Inpatient 2[ of Injury onth, Day Year)	1		8c. Injun	er: 4월 Nursing H	th (Check only o	one) dence 6 C	ther (Specify)	2□ No
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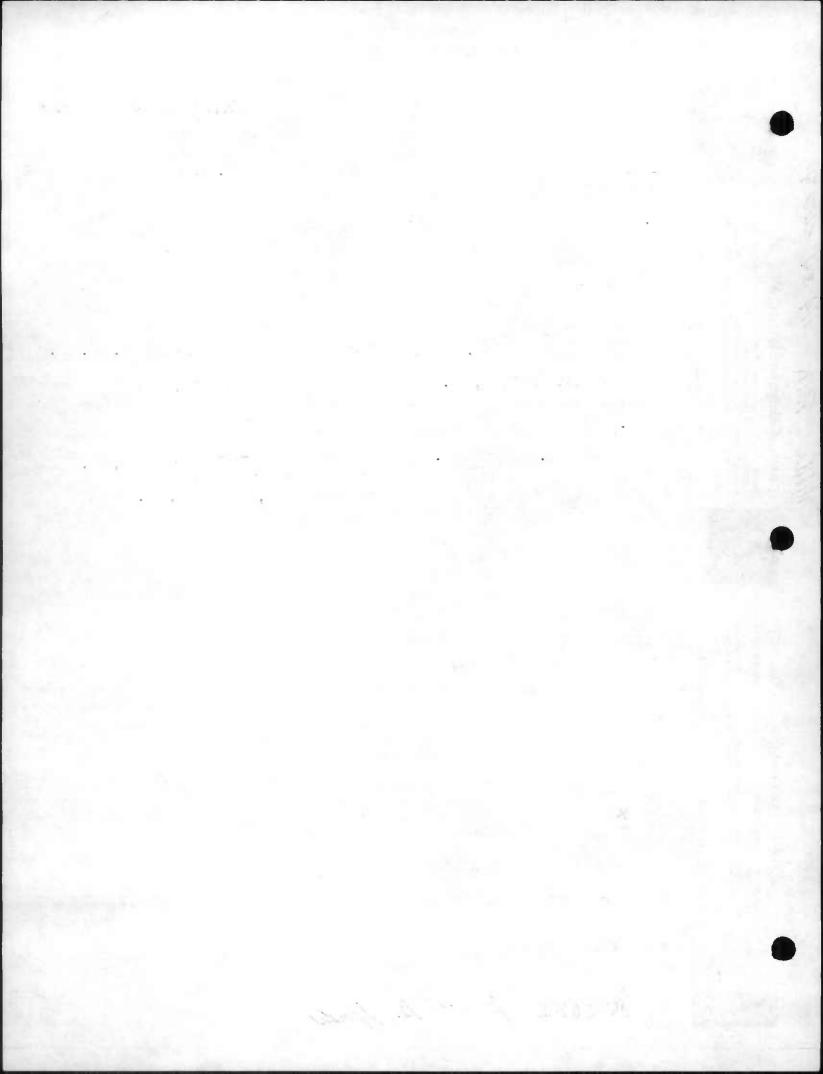


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 6 3 2 0

							Death			Reg. No.		
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hysician /Medical	HILD	A MARIE COT	TTMAN	POLK					January		2000	0805
xaminer	4a Facility Neme (If not institution,					4			cation of Deal	h 4c. Cour	nty of Death	
	PENINSULA RI 5. Sociel Security Number					r 1 Yeer		LISB			WICOMI	
neral ector	214-34-5627 Usual Residence of Decedent	6. Sex 7. A		last birthda; Yrs.	Months	Deys	Hours	Min.	8. Dete of Bit (Month, De DCT • 4	1939	PRII	place (State or Fo ntry) NCESS AN
ē u	10a. Stete 10b. County		10c. Cit	ty, Town or	Location						1	10d. Inside City L
Director	MD. WICOMI	CO	SA	ALISBL	JRY							1 Yes 2
be notified	10e. Street and Number			MAI	10f. Ziç					10g. Citizen o	of What Cou	ntry?
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Examiner must by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Tyes 2 Tild Yes, Give 7 Year or Detes	s? No	J,S. 13	3. Wes Dece if Yes, spe 1  Yes				ecify Yes or No Rican, etc.)	Special Specia	lace - Americ lack, White,	
ted bet	15. Decedent's (Specify only highest			16a. Dec	cedent's Usu	al Occup	ation	t of work	ina	16b. Kind of	Business/In	dustry
c the Medical.	Elementary/Secondery (0-12)	MASTER DEC	r 5+)		ve kind of wo		d)	i or work	ng			
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ician dical niner	23a. Pert 1. Enter the disease, or o shock, or haart tailure. List of the control	complications that caused not one ceusa of each	L AR	RYTH	m/A	de of dyin	g, such es	cardiac	or respiretory a	rrest,		Approximeta thervet Betwee Onset and Dee
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Harriet Elizabeth Payne February 5 2000 38:05 PM 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street and number) 4c. County of Death Sacred Heart Hospital Allegany Cumberland 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) Deys 1□ M 2 F Months Hours Min 213-22-4410 79 Yrs. Maryland Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street end Number 31 First Street 10g. Citizen of Whet Country? 10f. Zip Code 21532-ILS.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1□ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) **Dietary Department** hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Albert Jenkins Alice DeVault 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) John C. Payne, Sr. Husband 131 First Street Frostburg Maryland 21532-20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremetion 3 □ Removel from State Frostburg Memorial Park 4 Donation 5 □ Other (Specify) 08-Feb-00 Frostburg 21. Signeture of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, nock, or heert feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting In deeth) SEPSIS 1 WEEK Due to (or es e consequence of): DIVERTCULITIS, RUPTURED WEEK ACUTE Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequença of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Perl II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CA OF THE BREAST 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to CHRONIC OBSTRUCTIVE PULMONARY DISEASE completion of cause of death?

Physician /Medical Examiner

that the deeth certificate be executed

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certificate

After this funeral

efter death.

In by

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P.O. Box 68760.

Division of Vital Records.

or Attending Physician:

Hospital 24 hours filled

within 2

**Physician** 

'Medical

Examiner

10a. State

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the Maryland r 28a-f show a notified at

d 2 should be filed within 72 hours efter death with the hard Mental Hyglene.
7 is merked other than "natural", or frems 23a or : traumate event, the Mental and traumate event, the Mental and the manual and the traumate

Pages 1 end 2 si ment of Heelth end ant: If item 27 is r jury or other traur

Department of Important: If any injury or pace.

altimore, Maryland 21215-0020

Examiner physician and the burial-trensit Physician/Medical 88 USB ō ed by the a signed b þ Completed page 2 s director, Be To

25. Wes case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth

1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street end Number or Rurei Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 ☐ Suicide

1X Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examiner stand. minetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s)

28c. Injury at Work?

1 Yes 2 No

28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

Mer

eted cause of deeth (Item 23a) (Type, Print)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

29c. License number D24951

FEBRUARY 7,2000

29d. Date signed (Month, Dey, Year)

mis

Registrar

Certification:

edical

Chang Hyun Oh, M.D. 31. Date filed (Month, Day, Year, FEB 0 7 2000

30. Name and address of person who compl

32. Registrer's Signature

48 Tarn Terrace, Suite 204, Frostburg, Md. 21532

Homet Dize et Rome

Connections Allocatory

Sucred Hoor Hospital

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> Maryland Allegany **Emigisor**<sub>3</sub>

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Burst June of Region 5: Sout Ave. From thing 349-21532

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** JOHN SHERIDAN PHILLIPS, SR. FEBRUARY 5, 2000 1625 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY SACRED HEART HOSPITAL ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 20 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 MM 2□ F MARY LAND Yrs. 1919 80 Director 10 4748 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or hams 23s or 25s-f show 1 Yes 2 No Director MARYLAND ALLEGANY LaVALE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21502 U.S. 165 NATIONAL HIGHWAY Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: 3 Nidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) ENGINEER RAILROAD 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumetic event WALTER PHILLIPS CARRIE CUTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 CENTER ST., LaVALE, MD 21502 JOHN S. PHILLIPS, JR./SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/00 PHILOS CEMETERY WESTERNPORT, MD 21. Signature of Funerei Service Licensee 22. Nama and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Puluny Immediate Cause (Final Acui edeman den disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 1 cous CAD that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 2 years Renal Chanic Physician/Medical Due to (or as a consequence of) Vas dan didrac Perpha Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 2 signed b þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed?

Box 68760 P.O. Records.

Division of Vital Hospital or Attending Physician: 24 hours after death. Euneral Director: After this cartifica stely tilled in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completely filled in

8

25. Was case referred to medical examiner?

1 Yes 20 No

5 Panding investigation

6 Could not be determined

27. Megner of Death

Netural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Medical Certification: To WI

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

28a. Dete of Injury (Month, Dey Year)

Hospitel: 12 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. tnjury at Work?

1 Yes 2 No

29d. Date signad (Month, Day, Year) FEBRUARY 8, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Yes 2 No

1 Yes PNo

28d. Describe how injury occurred

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

berland MD Elian. M.D. 921 Seton

31. Date filed (Month, Dey, Year) FEB 0 8 2000 32. Registrer's Signeture

Could be made the second

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month February 4, 2000 DONALD EUGENE PAYTON 7:30 a.m. 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 302 S. Allegany Street Cumberland Allegany If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10M 20F 62 218-34-4678 1937 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 S. Allegany Street 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1. A Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Specify: white If Yes, Give Year or Dates: 1956-61 Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Self Employed Cumberland Limo 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Payton Dorothea (Robison) 19a. fnformant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wanda L. Payton 302 S. Allegany St; Cumberland MD 21502 208 Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Quriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cem2/10/ Flintstone, MD <sup>22</sup>Scarpelli Funeral Home P.A. Cumberland, Maryland that doused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1, Enter the dir shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 2000 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 kNo 3 Probably 4 Unknown unsim

**Physician** /Medical Examiner

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To the Hospital or Atta-within 24 hours after da To the Funeral Director complately filled in by th

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Certification: To

Medical

Attending Physicien: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Page Department of Important: If eny Injury or page.

Director

Funeral

Completed by

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filed within 72 hours after

21215-0020

altimore, Maryland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical 2 Completed

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

2000

25. Was case referred to medical 12 Yes 2 No released Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Feb.

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 TYes 2 □ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 1 Secrifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

D12532

(Check only one) 29b. Signature and title of partill 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

George Breza, M.D.; 912 Seton Drive; Cumberland, MD 21502 31. Data fifed (Month, Day, Year)

State Registrar

nu

FEB 1 0 2000

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

TEE DE COMO SERVE DE SERVE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** FEBRTUARY 15 2000 1:15 AM RUTLEDGE AUDREY MAURINE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year 5. Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Hours 10 M 20 F Months Yrs. 305-30-0777 84 1915 Michigan Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Health and Mental Hyglens. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic avent, the Medical Exeminar must be notified at once. 1 Yes 2 No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court #1402 20650 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Pest Control 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B Edna Hauger Ralph L. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lonnie B. Rutledge/Son 13075 Hickory Avenue, Waldorf, Maryland 20601 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 02-16-2000 Waldorf, Maryland 21. Signature of Justical Servicer Ligarities 22. Name end Address of Facility
The Huntt Funeral Home, Inc. JOHN P. KNISLEY M01164 P.O. Box 156, Waldorf, Maryland 20604 mew 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical End Stage few mouths Examiner Examiner attending physician and for use as the burial-transit Attanding Physician: The law requires that the death certificate be asscuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 43 Unknown NITAL RECORDS, Š 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, B 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) DIVISION Of VI Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 | Yes 2 | No 2 Accident 24 hours efter deat Funerei Director: 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide ծ Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 47066 2-15.2000. Shoul 30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print) PHILIP J.BEAN MEDICAL CTR. P.O.BOX640 HOLLYWOOD, MD. 20636 AVANI D. SHAH M.D.

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

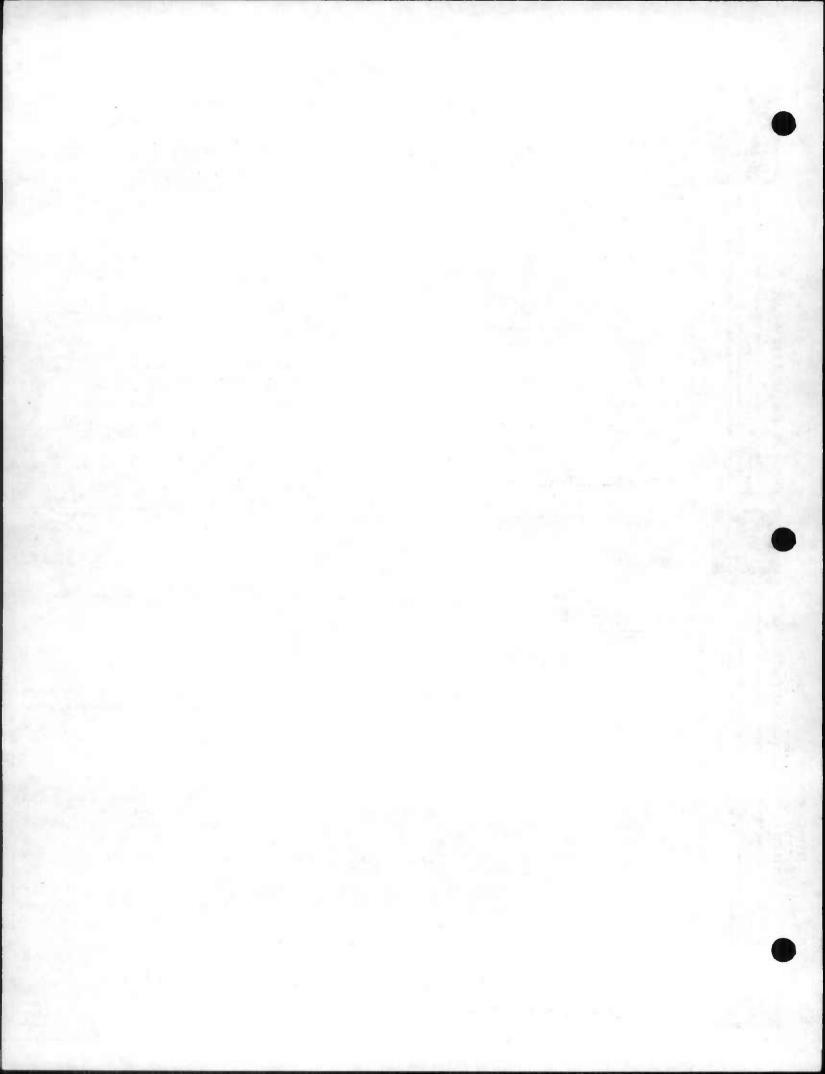
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32. Registrar's Signature



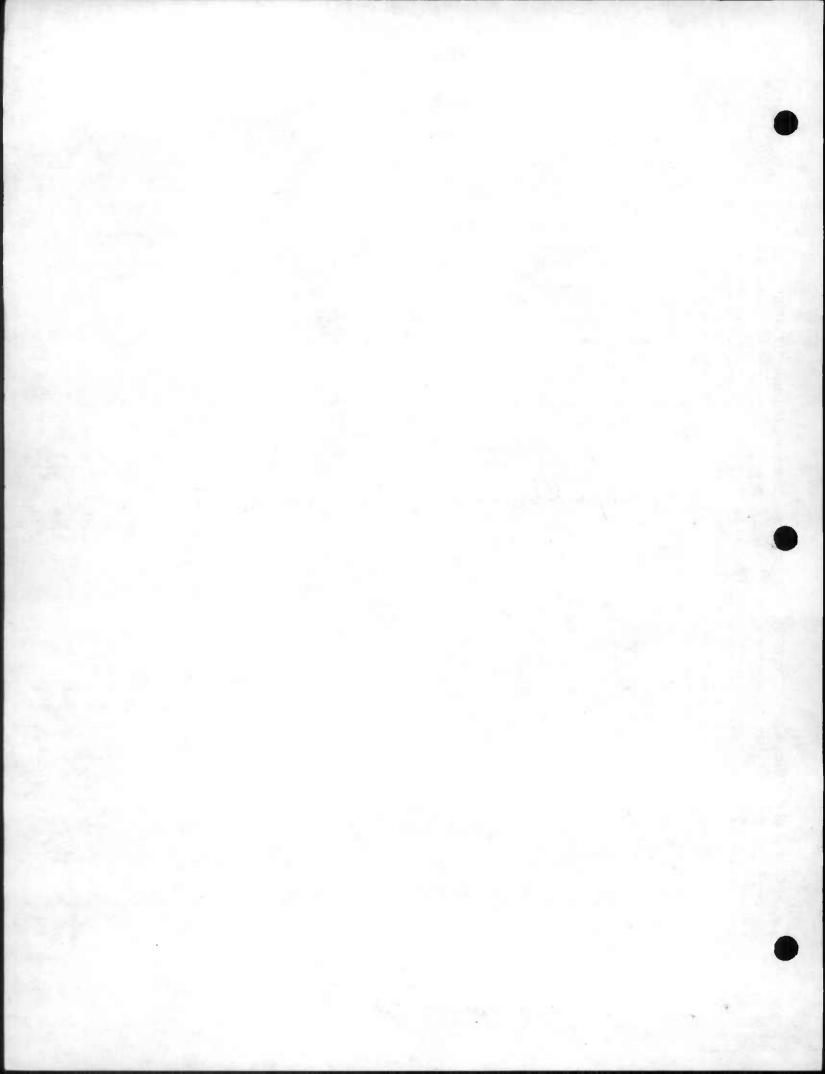
### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death February 7, 2000 **Physician** Elizabeth Mary Reilly 5:38 AM /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 5, 1903 Birthplace (State or Foreign Country) **Funeral** Days 10 M 200 Hours 184-10-8783 97 Yrs. Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Nes 2 No Director 288-1 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 200 East 16th Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Or Herna 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nant of Health and Mental Hygiene.
Int. It flow 27 is marked other than "natural", or fis 1 Never Married 2 Married altimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☒ No Specify: Specify: À 3 ₩idowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First Middle Last) Be J Lewis Scheifley Matilda. Miller 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a the fram 27 is or other tra Elizabeth Melanie Bryan/Niece 13001 Liberty Road, Union Bridge, Maryland 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremetion 3 ☐ Removal Irom State Department of Important: If any Injury or Smithsburg Crematory Feb 8,2000 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice 22. Name and Address of Fecility Keeney and Basford PA Funeral Home Enter the channe, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart finding. Ust only one cause on each line. 21701 Frederick, Md Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) END STAGE MZHOMORS years Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 980 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown 1. CPOPER EN SION þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? simorus page 2 2 No 1 ☐ Yes 2 ☐ No certificete Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Suursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Natural 2 Accident i or Attendin after death. Director: Aft 1 Yes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stele) To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 1. Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7, 2000 February 032171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALKOPSVING MD 21793 RICOURD GOVEH PO BOX 327 31. Dete liled (Month, Day, Year) FEB 0 7 2000 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

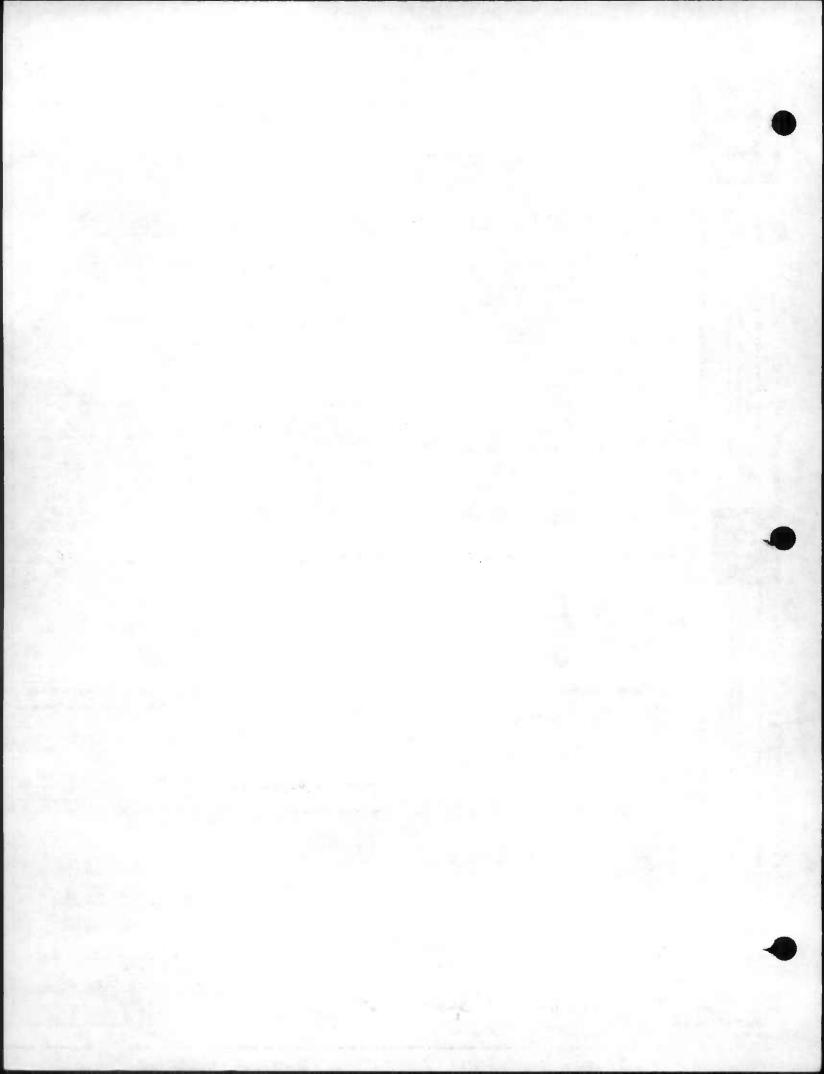


### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month SYLVIA REISLER **FEBRUARY** 4, 2000 3:25 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 X F Months 219-07-9529 93 Director Aug. 10, 1906 | Maryland Usual Rasidence of Decedant 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Frederick Frederick 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1421 Taney Village 21702 238 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 No 1 Nevar Married 2 Married ŏ Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Yas Giva þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 6 seamstress Frederick Tailoring 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Thomas Frank Soper Emma Catherine Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Department of Health as Important: if Nem 27 is any Injury or other traus Mary C. Wachter / daughter 7317 Ridge Rd., Frederick, MD 21702 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Rocky Hill Cemetery 2/7/00 Woodsboro, MD 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility Stauffer Funeral Homes, P.A. garepullo Ku-1621 Opossumtown Pike, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Ceusa (Final disaasa or condition rasulting In death) /Medical Examiner Dua to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): P.O. Box 68760. that Initiated evants resulting in death) Last Due to (or as a consequence of): 88 for use i signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown of Vitai Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ulertio 1 Yes 2 No 1 Yes 2 No neurone or Attending Physician: 25. Wes case rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No After this 28a. Deta of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? Division 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident the 24 hours after deat Funeral Director: 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 T Homicide Hospital 29a, Certifian 1 Certifying Physician: To tha bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 \$ 29b. Signetura and title of certifian 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) w. Ah ST; Frederick My 21701 31. Data filed (Month, Dayes rancis State

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month Dey February 6, **Physician** Albert Melvin Ringer 2000 1:20am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1MM 2□ F 214-10-2411 86 Mar 10, 1913 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Maryland Frederick Frederick 1⊠ Yes 2 No Directo notifie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Latham Drive 21701 Berns 23s U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1944— If Yes, Give Year or Dates: 1946 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: White Specify: þ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Sher then "n Elementary/Secondary (0-12) 12 College (1-4or 5+) Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event Be John Melvin Ringer Judith Wilson Fannie 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Eyler Road, Thurmont, Maryland 21788 Judith A. Ott, Daughter 20b. Place of Disposition (Name of commetery, cremetory or other piece)
Smithsburg Crematory Feb 7, 2000 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Struture of Funeral Service Licenses 22. Name and Address of Fecility
Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 2 days Examiner Due to (or as a consequence of): Physician/Medical Examiner 20 days femoral neck fracture physician end the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Alzheimer's Disease 10+ years that initiated events resulting in death) Last Due to (or es a consequence of): USA 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Colon Cancer à The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Benign Prostatic Hypertrophy 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1KI Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 WYes 2□ No this funeral 28a. Date of Injury (Month, Day Year) Jan 16, 2000 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: After or Attending 6:00 a M 5 Pending investigation A hours after des.

A hours after des.

And house after des.

And house after des. 1 Natural Subject fell while walking 1 Yes 2X No 2X Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Flurel Route Number, City or Town, Stete) 1820 Latham Drive 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 ☐ Homicide Frederick, Maryland At home 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as stated.

2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 07, 2000 D35164 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Andrew Zarick, Jr,

31. Date filed (Month, Day, Year)

MD FEB 0 8 2000

Box 68760,

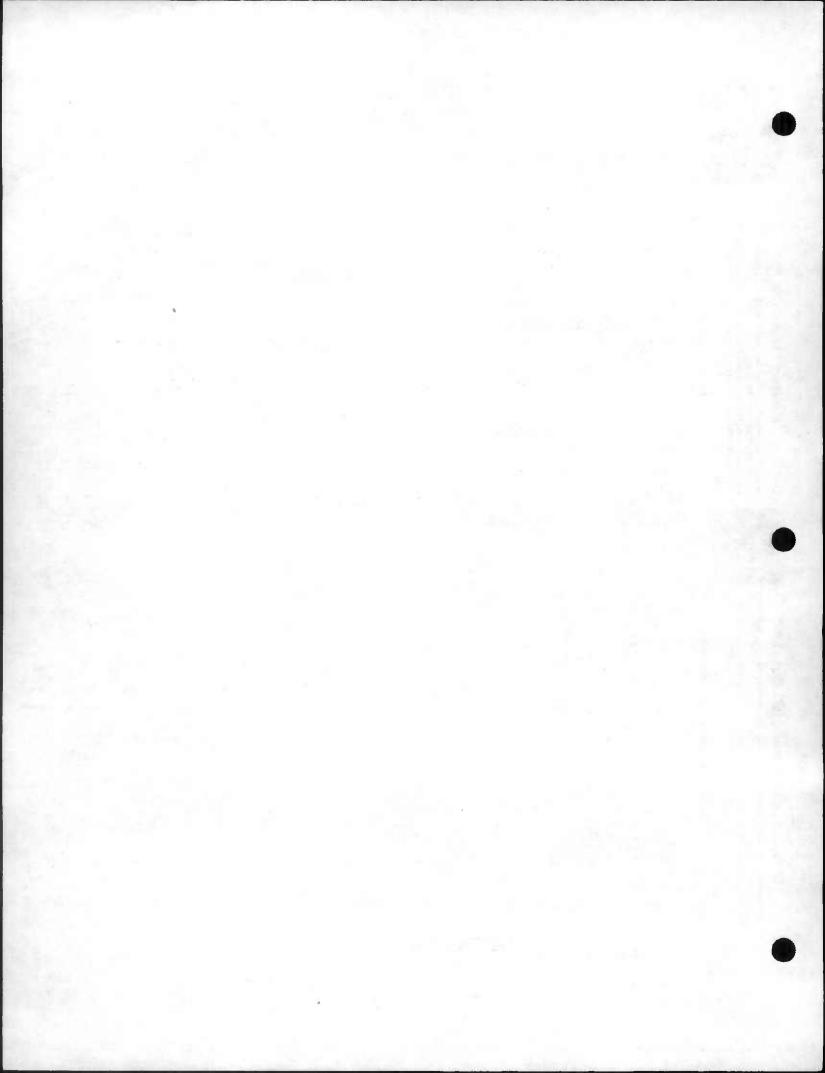
P.O.

Records,

of Vitai

Division

1080 West Patrick Street, Frederick, Maryland 21703



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middle, Last)	State of Maryla		tificate of			eg. No.	0 -0	3. Time of Death
Physician /Medical	Ethel M	1.	Rudl	off			28, 200		2:50pm
Examiner Funeral Director	4a Facility Name (If not institution, give s 157 N. Mechanic  5. Social Security Number 232-60-8226  6. Sex	Street A	pt. 2 rs. last birthday) 66 Yrs.	If Under 1 Year Months Days	4b. City, Town, or Lo  Cumberla  If Under 24 Hrs.  Hours Min.		4c. County (	Alle	egany ce (State or Foreig
a show ed.at	Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo					100	d. Inside City Limits
ter death with the Maryis therm 23e or 25e-f sho ther must be notified at Furneral Director	MD Alleg 10e. Street and Number 157 N. Mechanic		Cumberland  10f. Zip Code  reet Apt. 2 215				0g. Citizen of W	mat Country	Λ
urs after death v ef, or here 23s Examiner must by Funeral	11, Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Wes Decedent of I f Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American k, White, et whit	c.
ygiene. Net than 'natura', the Medical S	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occur kind of work done DO NOT use retire	pation during most of work od)		16b. Kind of Bu	siness/Indu	
Viental Hygi rivad other rific event, I	17. Father's Name (First, Middle, Last) Henry James				18. Mother's Neme Freda		mame)		
aith and i	19a. Informant's Neme/Reletionship (Tyr. Frank D. Rudlof				and Number or Run anic Str				
operations to execute a service and service as the burdel-transit and serv	23a. Part1. Enter the disease, or comparished.  23a. Part1. Enter the disease, or comparished.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Difference on the course on each line.  Of the course on each line.  Due to	li	cumber1 er the mode of dyi  en al  juence of);  Web Market  juence of);	and, Maring, such as cardiac of	yland	21502	2	Approximate nierval Between Onset and Death
sate has been signed by the attending plage 2 should be detached for use as Completed by Physician/Mec	Part II. Other aignificant conditions cont  Maffel obes:  Hypothysis	The start of the s	esulting in the u	distants m	ven in Pert I.	23b. Did to 1	n autopsy med?	3 Probe	the cause of deat tably 4 Unkno e eutopsy findings lable prior to pletion of cause eath?  Yes 2 No
s certification director	27. Menner of Death	ospital: 1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	☐ ER/Outpatier	I SU DON			ence 6 Othe	ar (Specify)	
within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral Medical Certification: 1	Description   Description								Route Number,
n 24 hours ne Funerel pletely filled edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	clan: To the best of my ker: On the basis of examinand manner steted.	nowledge, deeth nation and/or in	occurred at the ti vestigation, in my	me, dete and place, opinion, death occurr	and due to the cred et the time, d	ause(s) end ma late and piece, a	nner as sta and due to t	ted. the cause(s)
To the Comp	29b. Signeture and title of certifier  N.A. Gr	jithey		29c. Licens	9318	2	9d. Date signed Jan	31,	
)	30. Name and address of person who com N A Ranjithan M 31. Date filed (Month, Day, Year) JAN 3 1 2000		Oldtow:		Cumberla	and MD	21502		

DHMH 16 Rev 6/95

complete many contract

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death LOAR REYNOLDS **Physician** 6:30 PM 2000 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** POTOMAC VALLEY NUNSING CENTER ROCKVILLE MONTGOM ERY If Under 1 Year Months Deys if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10 M 20 E 233-26-5907 Usual Residence of Decedent 1,1908 MANY LAND Director 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner name be notified at 1 XYes 2 No NASHINGTON Directo 10e. Street and Number 10g. Citizen of What Country? ò INGLE STREET, N.W. 20016 items 23a 5031 Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 6 1 Yes 2 No 3 Widowed 4 □ Divorced Specify: WhiTE "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HIGH School TEACHER 17. Father's Name (First, Middle, Last) Be h and Mentel F MANY ANN GREENHORN LOAR P L 19a. Informant's Name/Relationship (Type, Print) (NISCS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: if Item 27 is any injury or other training. MANY ANN MEKENZIE CLAM SON, S.C. 2963 / Date 20c. Location - City or Town, State KNIGHT CIL. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other piece) QUEENS POINT GENETERY 2/9/00 Key SER 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FUNCIAL HOME 111 S, MINERAL ST. Keysen, WU 26726 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errests shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In deeth) Last pue signed by the attending physician dbe deteched for use as the Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificete hes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No ofter death in by the

The lew requires that the deeth certificate be executed Box 68760 P.O. Division of Vital Records, Hospital or Attanding Physician:

Pages 1 and 2 should be filed within 72 hours efter

21215-0020

Maryland

Baltimore,

within 24 hours of To the Funeral ( completely the my

death.

Registrar

3 Sulcide

29a. Certifier

4 Homleide

(Check only one)

29b. Signeture and titl

6 Could not be determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

SILVER SPRAG MY DR

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SAMENCEY AND AND 128 3 308 6 35 M response to the contract of th all the last results are one of the THE LONG CONTRACTOR OF THE PARTY Frankly Suited S. Kalende F13 4 3000 The Transfer of the State of th with the second of the last potterior 464219 FEB 0 7 2000 Leave & Speaker

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dev Mary H. Radcliffe 2000 4:20 AM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 817 Roeth Ave. Allegany 9. Birthplace (State or Foreign Country) Cumberland If Undar 24 Hrs. 8. De 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys Hours 1 M XXF Months Yrs 212-38-5784 91 Mar. 22, 1908 Maryland Usual Rasidanca of Decadent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Allegany Cumberland 10e. Street and Number 10f Zip Code 10g. Citizan of What Country? 817 Roeth Ave. 21502 USA 14. Raca - Amarican Indien, 12. Was Dacadent Ever in U.S. Armed Forcas? Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritel Status Bleck, Whita, atc. 1 Never Married 2 Married ☐ Yas 2 No f Yas, Giva 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Yaar or Detas: 16a. Decedant'a Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) School Teacher County Government 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) George William Haines Ann (Morgan) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) James H. Radcliffe 440 Mountain Glen Rd., Anaheim, CA 92807 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from State Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 2/7/00 Cumberland, MD 21502 22. Name and Address of Fecility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, 23e. Part1. Entar tha disease, or complications that shock, or heart feilure. List only one cause on Approximate Intervel Between Onset end Deeth Immadiate Ceuse (Final disease or condition rasulting in death) Due to for as a Sequentielly list conditions, if eny, laading to immadiata causa. Entar Undarfying Causa (Diseasa or Injury that initiated eventa resulting in daath) Lest Due to (or es a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 96 24b. Were eutopsy tindings available prior to completion of cause ot deeth? 24e. Was an autopsy 1 Yaa 2 No 1 Yas 2 No

**Physician** /Medical Examiner

Examiner

Physician/Medicai

þ

Completed

Be

10

Certification:

Medical

29a. Cartifier

(Check only one)

permit. Pages 1 Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be 10

**Funeral** 

Director

worle

if Health and Mantal Hygiens. Hem 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiena.

Maryland 21215-0020

altimore.

Box 68760,

P.O.

of Vital Records,

Division

the Manyland

deeth

usa as the bunel-transi Bnd 8 this

The law requires that the death certificete be executed or Attending Physician: After after death.

I Director: Aff 24 hours a Funeral D

25. Was casa referred to medical axaminar?

1 Yas 2 No 27. Mannar of Death 1 Naturel 5 Panding Investigation

2 Accident 3 ☐ Sulcide 4 Homicida

6 Could not be datermined

28a. Deta of Injury (Month, Day Year) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Hospital:

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Other: 4 Nursing Home 5 Assidanca 6 Other (Specify)

28d. Dascribe how Injury occurred

26. Placa of Death (Check only ona)

29b. Signatus and title of certifier

29c. I Icansa number

on who completed cause of death (Item 23a) (Type: Print) 30. Name and address of pe Beverly Calkins, 31. Data tiled (Month, Day, Yaar) Μ.

FEB 0 4 2000

D. 500 Memorial Ave., Cumberland, MD 21502

**DHMH 16 Rev 6/95** 

To the Hosp within 24 hor To the Fune completely fi

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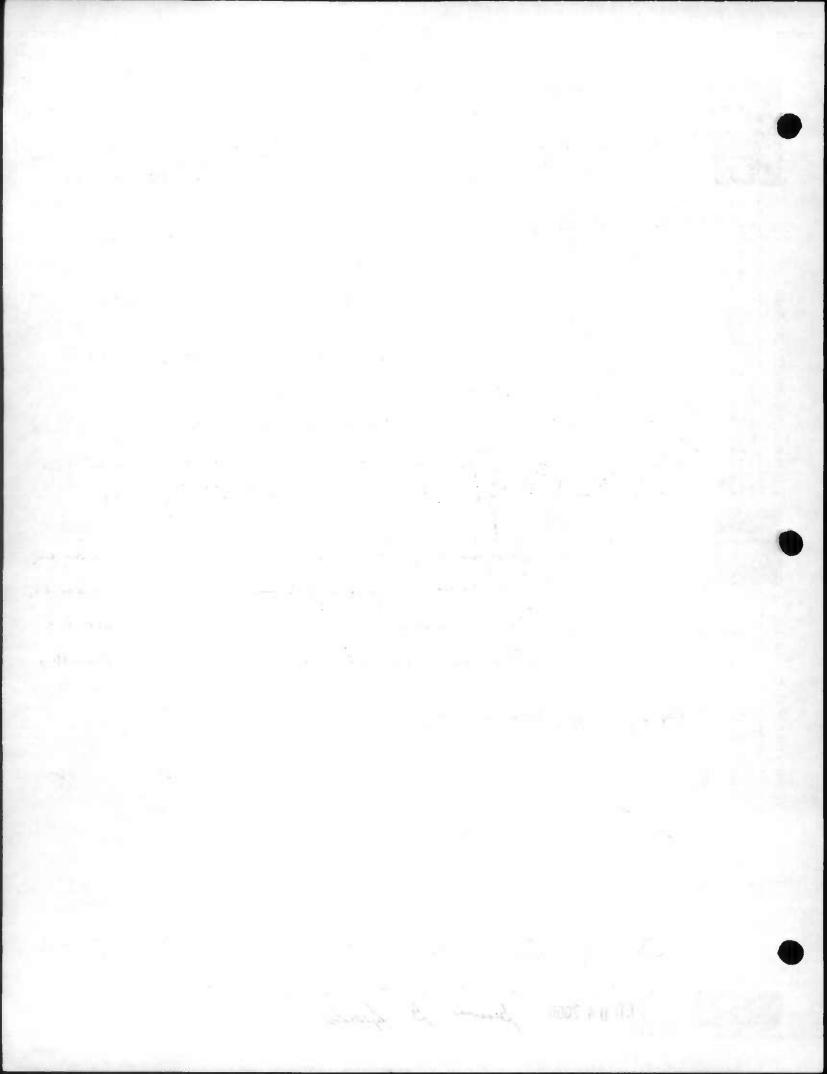
Mes

State

Registrar

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Yaar)



							rtment o	of Death		Reg. No.		00001	
		1. Decedent's Na	ama (First, Middle, La	ist)		477	200	12 14	2. Date of I	Death Day	Year	3. Time of Death	
Physicia /Medic Examin		Eddie	Lee Roger	s, Jr.					Janua		2000	7:15 P.M.	
		4a Facility Name	(If not institution, gi	e street and numbe	or)			4b. City, To	wn, or Location of Dec		nty of Dea		
			ge River	Road					nington		arret	t	
Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthdey)  15 Yrs.  6. Sex  7. Age (In yrs. last birthdey)  15 Yrs.  15 Yrs.								Birth Day, Year)	9. Bir	thplace (State or Foreignuntry)	
Director		236-25-6413 Yrs. 15 Yrs. World's Days Hours Feb. 10, 1984 Ma											
		10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits	
E D	tor	Md	Garret	t	Blo	omin	gton			Nes 2□Ne			
25 H	Directo	10e. Street and N	lumber				10f. Zip Coo	le		10g. Citizen o	of What Co	ountry?	
rns 23a or 28a-f shor c mant be notified at	1	49 Savage River Road 21523							Unite	ed St	ates		
Name :	Funeral	11, Marital Status		12. Was Deceder Armed Force	nt Evar in U,S.	13. W	/as Decedent	of Hispanic Ori	gin? (Specify Yes or h		ace - Ama	arican Indian,	
or in	15	1 Never Ma	arried 2 Married	1 ☐ Yas 25			☐ Yas 2√2		i, r deito riioari, etc.)				
Ers.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					X	Specify.		Spec		hite	
-neth	ete	(Spe	15. Decedent's E secify only highest gr	ducation ade completed)	16	a. Deced	ent's Usual Oc and of work do	cupation one during mos tired)	t of working	16b. Kind ot Businass/Industry		/Industry	
Man Selection	Completed	Elamentary/Sec	condary (0-12)	College (1-4o		dent	tirea)		West		ol		
HAD WELL			e (First, Middle, Last	)				18. Mothar's Name (First, Middle, Maiden Sumeme)					
Pages 1 and 2 should be inert of Feath and Mental rist. If them 27 is marked or my or other traumetic eve	o Be	Eddie Lee Rogers, Sr. Libby							y Holste	Holstein			
	-	19a. Informant's Name/Ralationship (Type, Print)  Libby Holstein / Mother  19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, St. 49 Savage River Road Bloomington, M. 20a. Method of Disposition  20b. Place of Disposition (Neme of company or other place)  Date 20c. Location - City or Town, St. 49 Savage River Road Bloomington, M. 20b. Place of Disposition (Neme of company or other place)											
										n - City or	Town, State		
			2 □ Cremation 3 □ n 5 □ Other (Speci	tery	2/6/2000	2/6/2000 Bloomington, MD							
y inte		21. Signatura of I	Funeral Septice Lice	nsee /	0			Idress of Facili	h.	111 Chur		-	
9228		+	Nay	esson		В	oal Fun	eral Ho				MD 21562	
		02a Dodd Enter	r the disease or con	plications that caus	ed tha death. Do	not enta	r the moda ot	dying, such as	cardiac or raspiratory		-	Approximate Interval Between	
		shock, or he	eart tailure. List only	one cause on each									
nysician		shock, or he	eart tailure. List only	one cause on each								Onset and Death	
Medical		immediate Causa diseasa or condit	a (Final			5				DSPILYX	Ai	Onset and Death	
nysician Medical xaminer	,	immediate Causa	a (Final			JUR G	=> A1		PRESSION 1	DSBITAX	Ai	Onset and Death	
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Medical Certification: Division

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th Completely filled in by the funeral

hus

Registrar

5 Panding invastigation

6 Could not be determined

29c. License number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

TREM PERDILED DIO STRUCK 15005F

281. Location (Street and Number or Rural Route Number, City or Town, Steta) 49 Savage River Road

O.C.M.E.

January 31, 2000

Bloomington, Maryland.

30. Name and address of person who completed cause of death (itam 23a) (Type, Print) vin

01-30-2000

160MJU

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) LB 0 2 2000

29b. Signature end titla of certifier

1 Natural

2 Accident

3 Suicida

29a. Certifier

4 🗌 Homicide

32 Registrar's Signature

 $A^{M}$ 

7:02

HOME

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify)

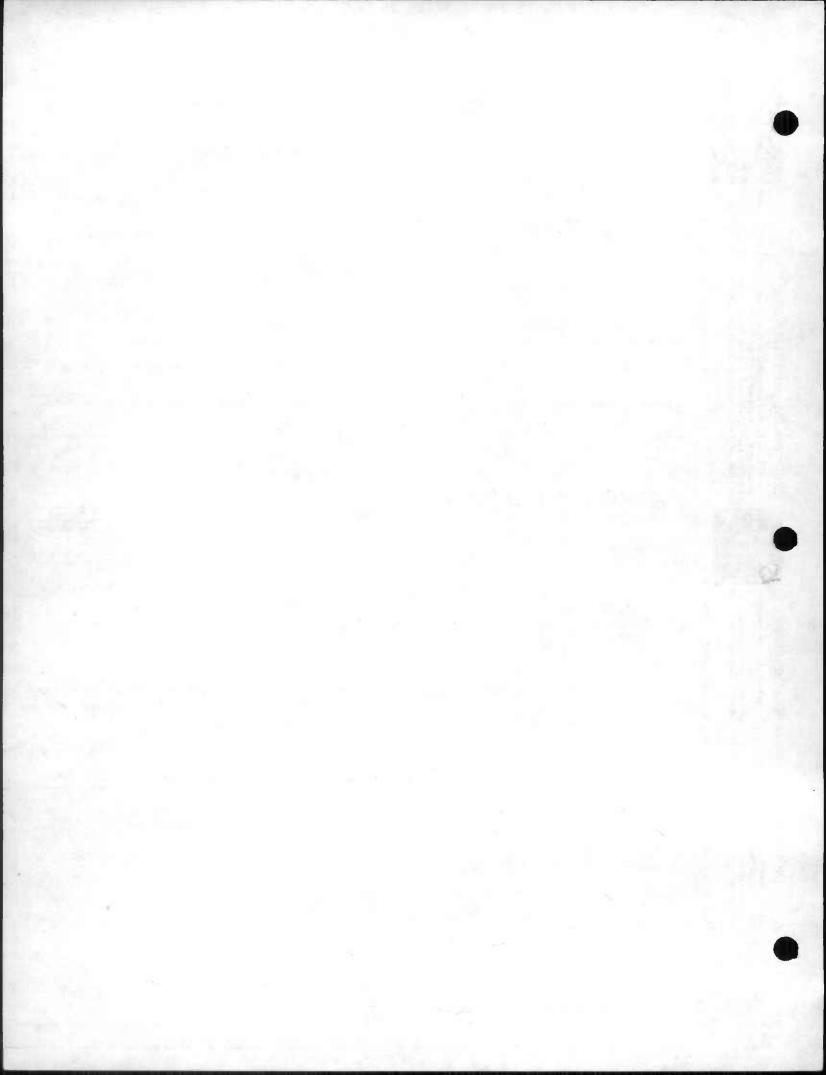
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### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Day Frank Philip Souza February 2000 2:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick
If Under 24 Hrs. Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Funeral Days 1♥ M 2□ F Months Hours Director 018-16-8991 Massachusetts Usual Residence of Deceden the Meryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Director Md. Frederick **Knoxville** 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or heme 23a or 2 with injury or other treumatic avant, the Medical Externior must be an once. 1705 Jefferson Pike Funeral 21758 USA 12. Wes Decedent Ever in U,S. Armed Forces? 112 Yas 2 ☐ No If Yas, Giva 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Never Married 2 Merried altimore. Maryland 21215-0020 1□ Yes 2√2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detas: 1945-1965 White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tavern 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be John Souza Jenny Madruga 19e. Informant's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gloria Souza, Wife 1705 Jefferson Pike - Knoxville, MD 21758 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/2/2000 Hagerstown, MD 21. Signeture of Funeral Service Licenses 22. Nama and Addrass of Facility John T. Williams Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final IImin disease or condition resulting in death) Examiner Examiner METABORIC DUZCUSE HOWIT HEART or Attanding Physicien: The law requires that the death carificets be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of) Hypothyrad Ism months P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No malnuteition been signed to should be det Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? diabetes mellitus vascular disease 1 ☐ Yas 2 No 1 ☐ Yas 2 No funaral director, 25. Was casa referred to axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al
complately filled in by the fu 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Certifier To the 29b. Signetura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) allul Al 000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) P. RUBIN 201 31. Data filed (Month, Day, Year) 0 3 2000 Agriculture State Registrar

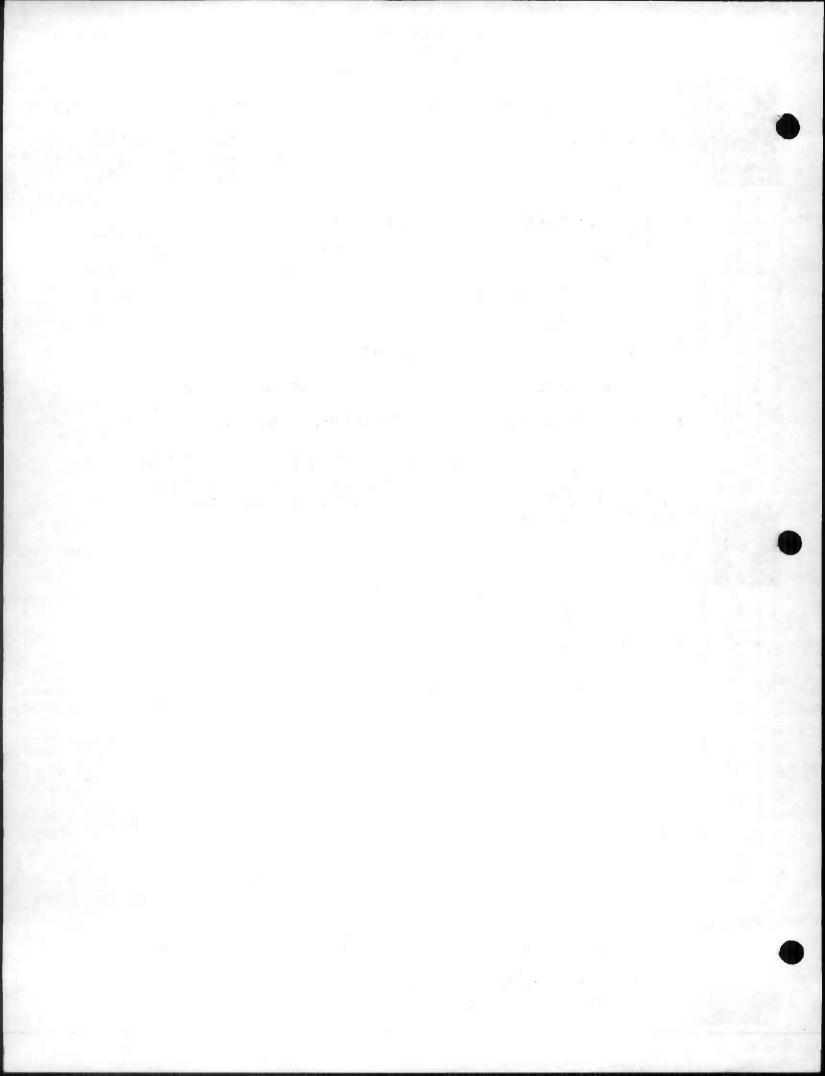


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** 1, Ralph Leon Sigler Feb. 11:30 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 224 Broad St. Middletown Frederick 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 → M 2 F 215-14-1236 Yrs. 80 Director Nov. 6, 1919 MD. Usuel Rasidence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic avent, the Medical Examiner must be notified at Yes 2 No Director MD. Frederick Middletown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 224 Broad St. 21769 items 23a U.S.A. death Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after d Department of Heelth end Mental Hygiene. Important: If item 27 ie marked other than "naturel" and injury or other traumetic averages. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify:White by 3 Widowed 4 Divorcad Completed 15. Decedant's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Collage (1-4or 5+) Elementery/Secondary (0-12) mechanic aircraft 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) John H. Sigler Elizabeth Butts 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) A. Marie Sigler (Wife) 224 Broad St., Middletown, MD. 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 5 ☐ Other (Specify) Locust Valley Cemetery 2/4 Middletown, MD. 22. Name and Address of Fecility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769 tio is thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, calls on each line. Approximeta tntarvat Batween Onset end Deeth **Physician** /Medical tmmediete Ceusa (Final 1 ust disease or condition resulting in deeth) Examiner Examiner Linnis physician and s the bunal-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or Injury thet initiated events resulting in deeth) Lest Due to (or es a consequença of): Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): attending p Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of deeth? been signed by the should be datached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings eveileble prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? paga 2 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes casa referred to medical 26. Place of Deeth (Check oply one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manper of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Panding investigation 1 ☐ Yes 2 ☐ No 4. 4. 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Cartifiar Medical (Check only one) 29b. Signeture end titla of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 00 3 30. Nema end addrass of person who complated causa of death (Item 23a) (Type, Print) 800 31. Dete filed /Month State Registrar

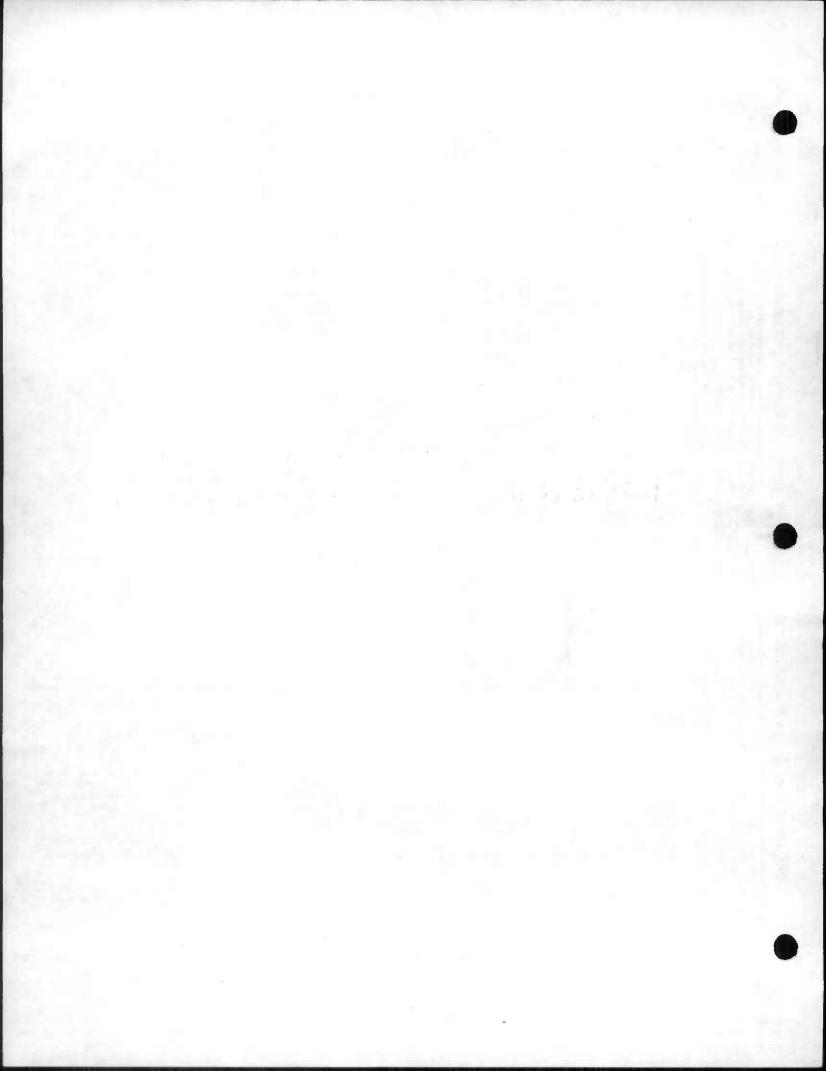


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State of Maryland / Department of Health and Mental Hygiene

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				Cei	tificate d	of Deat	n		Reg. No.			
Physician /Medical		Pearlene	Shaw					2. Deta of De Januar		oŏ <del>o</del> r	3. Tima of Death 4:50 PM	
Examiner	An Capitity blama Mant institution						rown, or La leric					
Funeral Director	5. Social Security Number 213-42-1692 Usual Rasidence of Decedant	6. Sex 1□ M 2√7 F									lace (State or Foreign itro) y Land	
Maryland a-f show illed at	10a. Stata 10b. County	erick		y, Town or Lo edericl			67			1	0d. Inside City Limits	
her death with the Maryta Rems 23e or 28e-1 shoulder and Interment bit action	10e. Street and Number 105 Crosstimber Way 21702								10g. Citizen of V U.S.A.	What Cour	ntry?	
72 hours after death vinetures; or items 23 dicel Examiner must		ied Armed Fe 1 ☐ Yas If Yas, Gi	12. Was Decedent Ever in U,S. Armed Forces? 1 Yas Who H Yas, Giva Yaar or Datas:			13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:  1 Yes 2 No Specify:			Blac	14. Race - Amarican Indian, Black, Whita, atc. Specify: White		
d 2 should be fried within 72 hours at 2 ahould be fried within 72 hours at 7 is marked other than "natural", or traumatic event, the Medical Exam.  To Re Completed by	15. Deceden (Specify only higher Elementery/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker			16b. Kind of B			
Mantal Hyperited office event,	17. Fathar's Nama (First, Middle,	17. Fathar's Nama (First, Middle, Last) Benjamin Lewis					18. Mother's Name (First, Middle, I Altie					
CENT	19a. Informant's Name/Ralations Mr. Larry C. C.			105 (	Crossti	mber W			ck, Md.			
mit. Pages 1 a partment of Hea portant: if item y injury or othe	20a. Mathod of Disposition  1 ☐ Burial 2 ☐ Cramation  4 ☐ Donation 5 ☐ Other (S)	emetery, cren	sition (Name or natory or other et Cemete	place)	2, 2	Date 2000	20c. Location - City or Town, State Frederick, Md.					
Physician	21. Signatura of Funaral Sarvice  Ruchou  23a. Part1. Entar tha disaase, or shock, or haart teilure. List	Jark.		n. Do not ente	LO6 Eas er the mode of	and Ba t Chur dying, such a	sford ch St	Fre	neral Ho derick, urest,		21.701 Approximata Intarval Between Onset and Death	
/Medical Examiner	Immedieta Ceusa (Final disaasa or condition rasulting in death)	a		ras a conseq								
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ding se a	rasulting in daath) Last	d	Due to (or Lympho	as a consequence	uence of):							
hat the de de by the detached		Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension							23b. Did tobacco use contribute to the cause of de			
The law requires that the rate has been signed by the page 2 should be detache.							¥.		s an autopsy ormed?	ev	ere autopsy findings allable prior to mpletion of ceuse death?	
The page	25. Was casa reterred to medicel					26. Ple	ce of Deat	1 D	Yas 2 No	1[	Yas 2□ No	
hysician: his certific il director,		Hospital:	Inpatient 2)(	ER/Outpatien	t 3□ DOA	Other: 4	Nursing Ho	ma 5□Res	idence 6 □Oth	nar (Specil	(y)	
After fune	27. Mannar of Death 1 Netural 5 Pandin 2 Accident invastig	ation	of Injury th, Day Year)	28b. Time of Injury		njury at Work? I□Yes 2	□No	28d. Describe	how injury occur	red		
tal or Attending is after death. al Director: After led in by the fune Certification	3 Suicida 6 Could r 4 Homicida daterm	ined   288. Place	e of Injury - At ho ing, atc. <i>(Specif</i> )	ome, farm, str	eet, factory, offi	C9		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attendaming Within 24 hours after death or to the Funeral Director: completely filled in by the Medical Certifical			best of my know asis of axaminat nec stated.	wledge, death ion and/or inv	restigation, in m	ny opinion, d	eath occur	and due to the red at the time,	, date and place,	and dua to	o tha cause(s)	
To the Common	29b. Signatura and titla of certifian	272	nor b	w		00366			Januar		, 2000	
	30. Nama and address of person of Edward F. Fr	isher, M.	D., 56 7	Chomas		n Driv	e, Fr	rederic	k, Maryl	land	21702	
State Registrar	31. Data filed (Month, Day, Year)		legistrer a Signal	ture.	Spoon	Me!						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death January 31, 2000 4:30pm Shankle Sr Robert Lewis 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Birthplace (State or Foreign Country) If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Feb 7, 193 Days Months Hours M 2DF 218-24-9191 68 Maryland 1931 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits Frederick Frederick 1 DXYes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 1495 West Ninth Street 21702 U.S.A. 12. Wes Decedent Ever in U.S.
Armed Forces?
1 ②Yes 2 □ No 1948 If Yes, Give
Year or Detes: 1970 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried White 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Public Safety Fireman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Shankle. Mary Betts Delma David 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 4851 Mount Zion Road, Frederick, Maryland 21703 Mr Robert L. Shankle, Jr/Son 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete t Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Mt Olivet Cemetery Feb 5,2000 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funerel Service Lie M00706 106 East Church Street, Frederick, MD 21701 MOO/OS | 1C6 East Church Street, Free Part . Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. relecto Due to (or es a consequence of): Due to (or es e consequence of)

**Physician** /Medical Examiner

physician and the burial-transit

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certificate

this

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

uneral

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Completed

Be

Certification: To

Medical

Box 68760

P.O.

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

man be notified at

"natural", or Itema 23a or

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or han any Injury or other traumatic event.

Director

Funeral

à

Completed

Be

the Maryland

death

5. Social Security Number

Maryland

10e Street and Number

12

Lewis

10a State

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Physician/Medicai

Immediate Cause (Finel

disease or condition resulting in deeth)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributs to the cause of death?

meder a.

1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy

25. Was case referred to medical Hospital: 1 Yes 2 No

1□ Yes 210No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

27. Menner of Deeth 2 Accident 3 ☐ Suicide

4 Homicide

1 Inpatient 28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 ☐ Could not be

28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

D30496

29b. Signeture and title of certifier

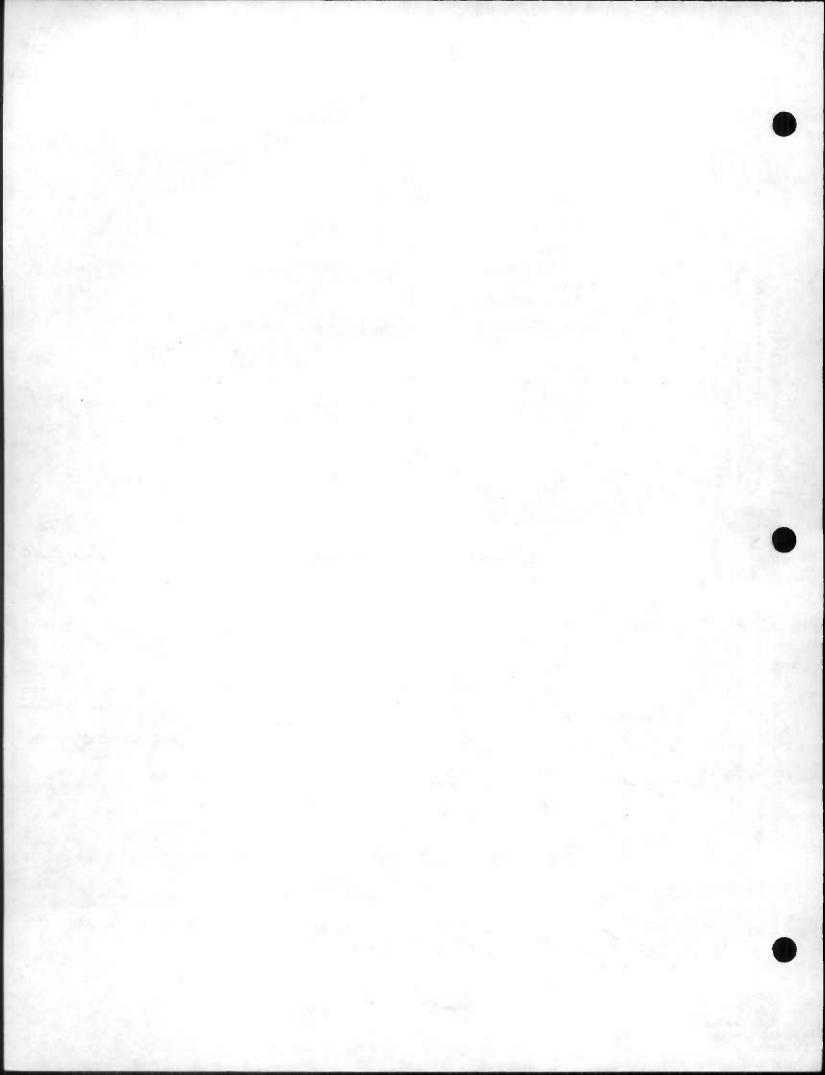
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number 29d. Dete signed (Month, Day, Year) February 03, 2000

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

300 West Ninth Street, Frederick, Maryland 21701 Francis E. Becker, M.D., 0 3 2000 Registre's Signeture

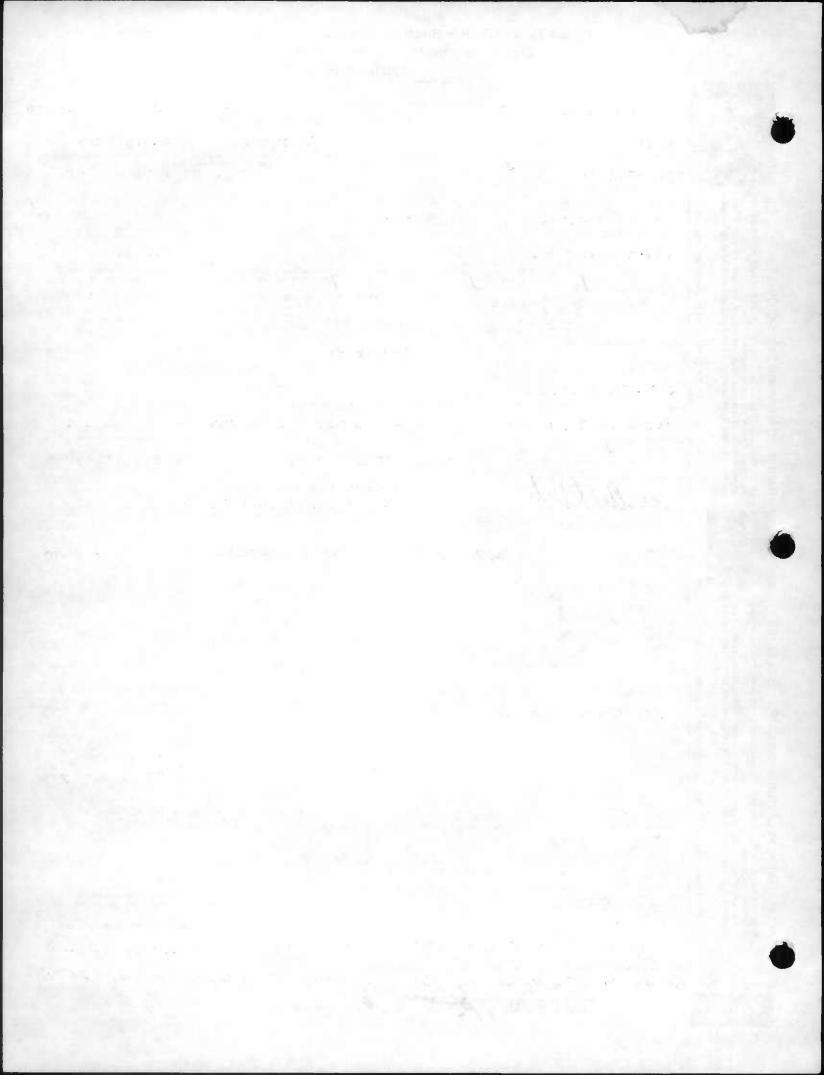
State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					C	ertifica	te of	Death		Reg. No.	JU	U 5 3	36
Physicia	an	1. Decedent's Name (First, Middla,					2. Date of I	2. Date of Death Month Day Yaar			of Death		
/Medic Examin	cal	GERALDINE S. 4a Facility Name (If not institution,		m <i>ber)</i>				4b. City, Town	Feb.	4, 2000 ath 4c. Count	O y of Death		)Oam
	•	16415 Comus	Rd.					Dicke	rson	Mon	tgom	ery	
Funeral Director		5. Social Security Number  219-48-6919  Usual Residence of Decedent	3. Sex 1  M 2  F	7. Age (In y	rs. last birthda Yrs.		If Under 1 Year If Under 24 Hrs. Anoths Days Hours Min. Super 29 1950  June 29 1950					placa (Stata ntry) MD	or Foraig
fand		10a. Stata 10b. County		10c.	City, Town or	Location					1	10d. Inside (	Dity Limits
Mary	to	MD Montgomery Dickerson									1 🗆 Yes	s 25 No	
h with the	al Director	10e. Street and Number 10f. Zip Code 16415 Comus Rd. 20842								10g. Citizen of U . S		ntry?	
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "natural", or items 23a or 23a-f show is marked other than "natural", or items 23a or 23a-f show auratic event, the Madical Examiner man be nothed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedant Evar in U,S Armed Forces 1 1 Yes 2 No If Yes, Sive Yaar or Dates:					edent of hecify dub	lispanic Origin an, Mexicen, F Specify:	? (Specify Yes or Puerto Ricen, etc.)	No- 14. Re Ble Speci	ick, White,	cen Indian, etc. hite	
within 72 ho	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1	I-4or 5+)	lor 5+)  16a. Decedent's Usual Occup (Give kind of work dona life. DO NOT use retire Secretary				f working	16b. Kind of E	16b. Kind of Business/Industry		
Hygier ther	00	17. Father's Name (First, Middle, L	26	CLE	ary	18. Mother's	Name (First, Midd	Middle, Maiden Sumama)					
and Mental I marked or	To Be	John R. Spat				Jean	nette Dr	yburgh					
d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationshi			19b. Ma	iling Addre	ss (Street	and Number	or Rural Route Num	ber, City or Town	, State, Zij	p Code)	
5 = 12 = 1		Jacob Smith/	spouse							son, M	D 2	0842	
		20a. Method of Disposition  1 Burial 2 Cramation 3 4 Donation 5 Other (Spe		State	enders			<sub>се)</sub> / F.Н.	2/5	20c. Location Berry		own, State	/A
permit. Pages Department of Important: If i any Injury or page.		21. Signature of Furneral Service Locenses  22. Name and Address of Facility Hilton Funeral Home Box 86 Barnesville, MD 20838											
Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that c nly one cause on e	eused the de each line.	eath. Do not e	enter the m	ode of dyi	ng, such as ce	rdiac or respiretory	arrest,	0838	Approxime Interval Be Onset and	etween
/Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in death)	a. ME		ATTC (or es a cons			- CA	NCEL			1 YE	gr_
cuted	amln	Sequentially list conditions.  Due to (or es a consequence of):							1				
death certificate be executed e ettending physician and d for use as the burlai-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertrying Cause (Diseasa or Injury that initiated events resulting in deeth) Last  Due to (or es a consequence of):  Due to (or as a consequence of):											
ath cer ttendir or use	lan		d										
	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  SYSTEMIC LUPUS								d tobacco use co			of deat
been s	Completed by								24e. We	es en eutopsy normad?	av Cc	Vere autopsy vailable prior omplation of death?	rto
0 - 0	a di								10	Yes ONO			SNO.
certificate rector, pag	Bec	25. Was cese referred to medical						26. Piace of	Death (Check on)	V	1		
5 00	To	examiner?	Hospitel: 1 🗆	Inpatient 2	☐ ER/Outpat	ient 3 🗆	DOA Oti	ner: 4 Nursi	ing Homa 578 Re	sidence 6 🗆 Ot	ther (Speci	ify)	
l or Attending Ph after death. Director: After thi d in by the funeral			anner of Death  Anatural 5 Pending   28a. Date of Injury (Month, Day Year)   28b. Tima of Injury Injury						28d. Describ	rlbe how injury occurred			
al or Afters after de il Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo								(Street and Num Town, State)	ber or Rui	al Route Nu	m <i>ber</i> ,
To the Mospital within 24 hours a To the Funersi C completely filled	edical (	29a. Certifier (Check only one) CertifyIng	caminer: On the ba	best of my kasis of exeminer stated.	nowledge, de Inetion end/or	ath occurre Investigetion	d at the ti	me, date and poplnion, deeth	place, and due to the occurred at the time	ne ceuse(s) end m e, date and place	nanner as a , and due l	stated. to the cause	(s)
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		1 /	ho completed caus	1							-		

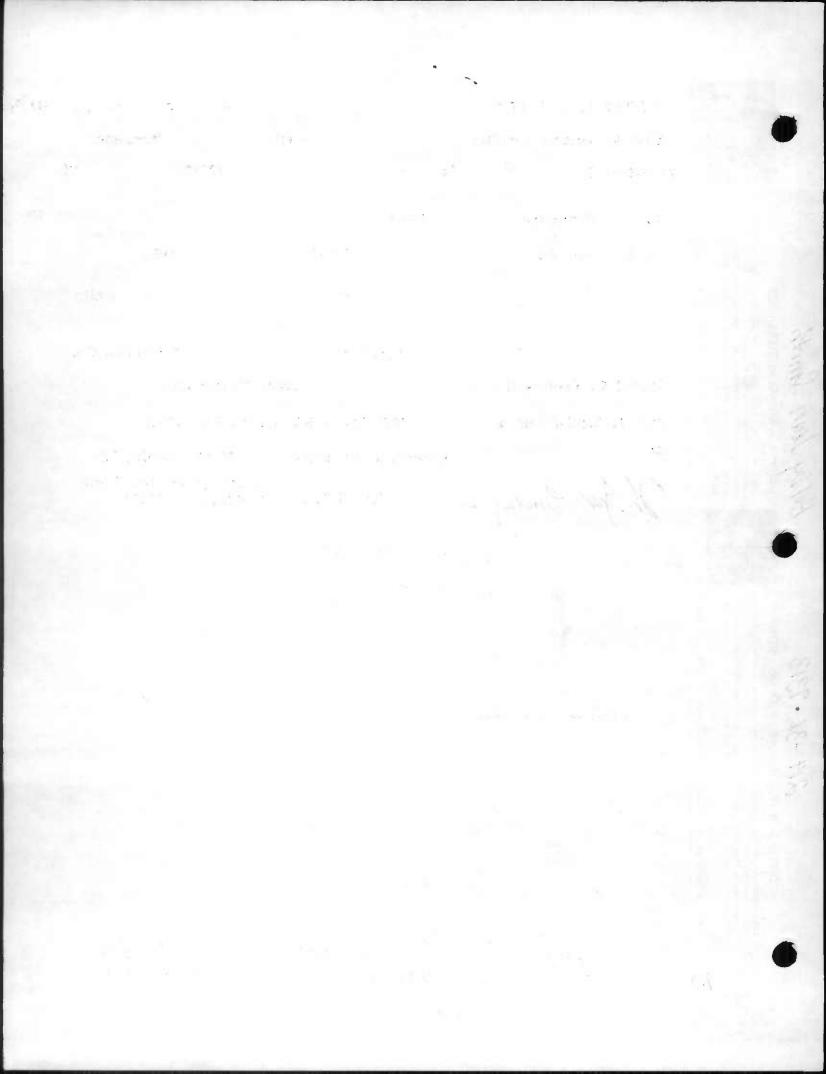


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 12:39 PM BOBBY JEAN SMITH 12 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin If Under 24 Hrs. 8. Date of Birth (Month, Day.) 9/7/36 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Days Hours Min 63 Yrs. DE 214-36-7313 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10d. Inside City Limits r 28a-f show 10a, State 10b Counts 10c. City. Town or Location 1 Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Maxical Examiner must be a 9055 Evans RD 21811 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Stalus Bleck, White, etc. 1 Never Merried 2X Married 1 Yes ≥ No Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) bby Lean Smith Elementary/Secondary (0-12) College (1-4or 5+) end Mental Hygiene. Operator Telephone Co. 17. Fathar'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Robert C. Pennewell Irene Hester Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) of Health e Paul J. Smith/ Husband 9055 Evans RD Berlin, MD 21811 other t 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o ©Burial 2 ☐ Cremation 3 ☐ Removel from State 2/15/00 Evergreen Cemetery Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ke of Funaral Service Licensee **Burbage Funeral Home** 108 William St. Berlin, MD Part. Error find disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or hear failure. List only one cause of each line. Approximata Interval Between Onset end Deeth Physician Immediate Cause (Final disaasa or condition resulting in daath) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours effer deeth. Funeral Director: After this certificate hes been signed by the ettending physician and physician end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ettending pl 214-36-7313 signed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 20 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate hes b director, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No funeral director, 25. Was case raferred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 🖸 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and placa, and due to the cause(s) and mannar as stated. 29a. Certifiar Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signature



### Ple

e. Facility Name (If not institution, gi	izabeth	Shof										
Homewood Retireme  Sociel Security Number 6.	un ntennt	piler	fler					2. Date of Deet	, <sup>D</sup> <b>2</b> 000	Yeer	3. Time of Death 11:45 AM	
	46. Facility Name (If not institution, give street and number) Homewood Retirement Center  4b. City, T Fred									c. County of Death Frederick		
219 14 0000	yrs. last birti		der 1 Year hs Days		24 Hrs. Min.	June 21	Year 1923	9. Birthpl Count	ece (Stete or Foreign			
Jsuel Residence of Decedent  10a. State 10b. County  MD. Freder	cick	100	c. City, Town	or Location	own					10	od. Inside City Limits	
Oe. Street and Number 4497 Willowtree	Dr.		*		Zip Code 21769			10	0g. Citizen of V		ry?	
Merital Status     Never Married 2  Married     Widowed 4  Divorced	12. Was Dac Armed F 1  Yes If Yas, Gi Yeer or D	orces? 2⊠No ve	in U,S.	13. Was Dec	cedent of I		gin? (Spo i, Puerto	ecify Yas or No- Rican, atc.)	14. Rac Blac	e - America ck, White, e	itc.	
15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)		1-4or 5+)		Decedent's Us (Give kind of s life. DO NOT	work done	during most	t of work	ing	16b. Kind of Bu	siness/Ind		
7. Fether's Neme (First, Middle, Last Henry W. Shef				18. Mother's Name				Finfrock				
Immadieta Cause (Finel disease or condition esulting in deeth)  Sequentially list conditions, fany, leeding to immediate ause. Enter Underlying Cause (Disease or injury het initiated events esulting in deeth) Lest	a. Cana b	Due	to (or es e c	onsequenca o	of):	rest					Onset and Death	
art II. Other eignificent conditions	d.	eath but not	resulting In	the underlying	g cause gi	ven in Pert I.		23b. Did to	bacco uee cor	ntribute to	the cause of death	
Progressive	demes	ntia	_					1 ☐ Ye	es 2□ No		ably 4 ☐ Unknow	
nalites	0	n de	10	1 2000	40	1000		perform	ned?	ava com of d	iiabla prior to ppiation of causa eeth?	
25. Wes case referred to medical exeminer?  1 Yes 2 No	Hospitel:	Inpatient	2 ER/Out	patient 3	DOA OII	h an		n (Check only on	9)			
7. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be determined	28a. Dete (Mon	of Injury th, Dey Yea	28b. Ti		28c. Inju Wo	ry et	No	28d. Describe ho 28f. Location (Str. City or Town	w injury occurr	red		
	nyelclan: To the	heet of my	laman da da a	d-adb								

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit To the Hospital or Attending Physician: The law requires thet tha death certificate be axecuted Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic svent, in Medical Evantment with the Incitind at

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

10

Physician/Medical Examiner

Be Completed by

Medical Certification: To

State Registrar 31. Data filed (Month, Day, Year)

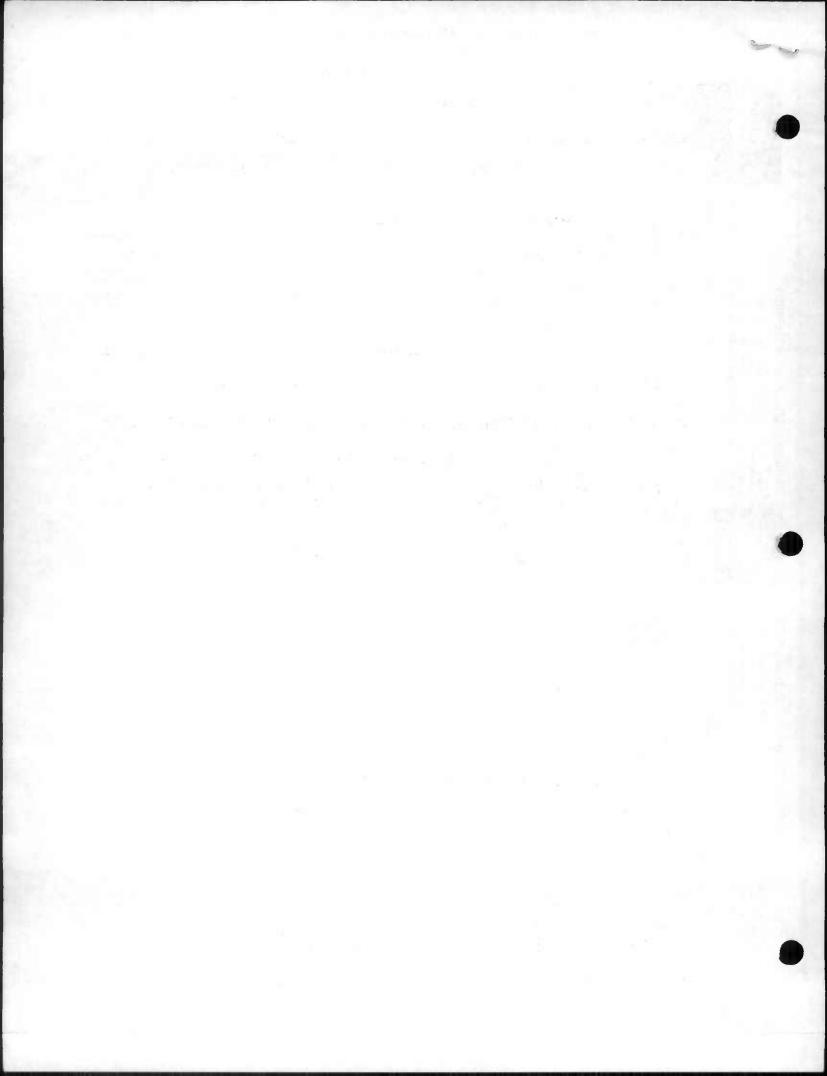
30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Adriana Hohl, Box 17, MiDDL

2000

32. Registrer's Signeture

MIDDLETOWN, MD 21769



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Feb 13, 2000 330 PM Virginia Louise Rawlings Scrivener /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) **Examiner** Prince right Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Mooth, Day, Year) Pevs Hours Min. Tully 1 1919 Maryland 1250 Stoakley Road 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 DF Yrs. 80 **Director** 220 48 3663 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince Frederick Maryland Calvert 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Counfry? 1250 Stoakley Road 20678 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Detes: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leila Elizabeth Bowen Thomas Benjamin Rawlings 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) S. Scrivener- husband 1250 Stoakley Rd. Prince Frederick MD 20678 Guy 20e. Method of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other place be 16, Central Cemetery 20c. Location - City or Town, State 2000 Barstow Maryland 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Nama end Address of Fecility Rausch Funeral Home PA 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. DROWSO Physician of- Color /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Diseasa or injury Dua to (or as a consequence of): Physician/Medicai thet initieted events resulting in death) Lest Due to (or es e consequence of) Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? Cuna 1 Yes 2 No 3 Probably 4 Junknown P 24b. Wara eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy Completed 1 Yes 2 10 No 1 Yes 2 No 25. Wes case rafarrad to medical examiner? 26. Placa of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Mannar of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending Neturel 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Sulcide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end mennar stated. 29a. Certifier edicai (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D 25435 Feb 14 2000

State Registrar

of filed within 72 hours efter death with the Manyland I hygiena.
Other than "natural", or frams 23a or 28a-f show only, the Modified Examinar man be notified at

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physician and s the burial-trans

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page 2

funeral

certificate

After

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efter deat Director:

24 hours

To the Hosp within 24 ho To the Fune completaly fi

P.O. Box 68760,

Records,

Division of Vital

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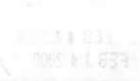
Saltimore, Maryland 21215-0020

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31. Dete filed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Prinf)

Mukesh Mathur, M.D. 110 Hospital RD. Suite 305 Prince Frederick MD8 32. Registrer's Signeture

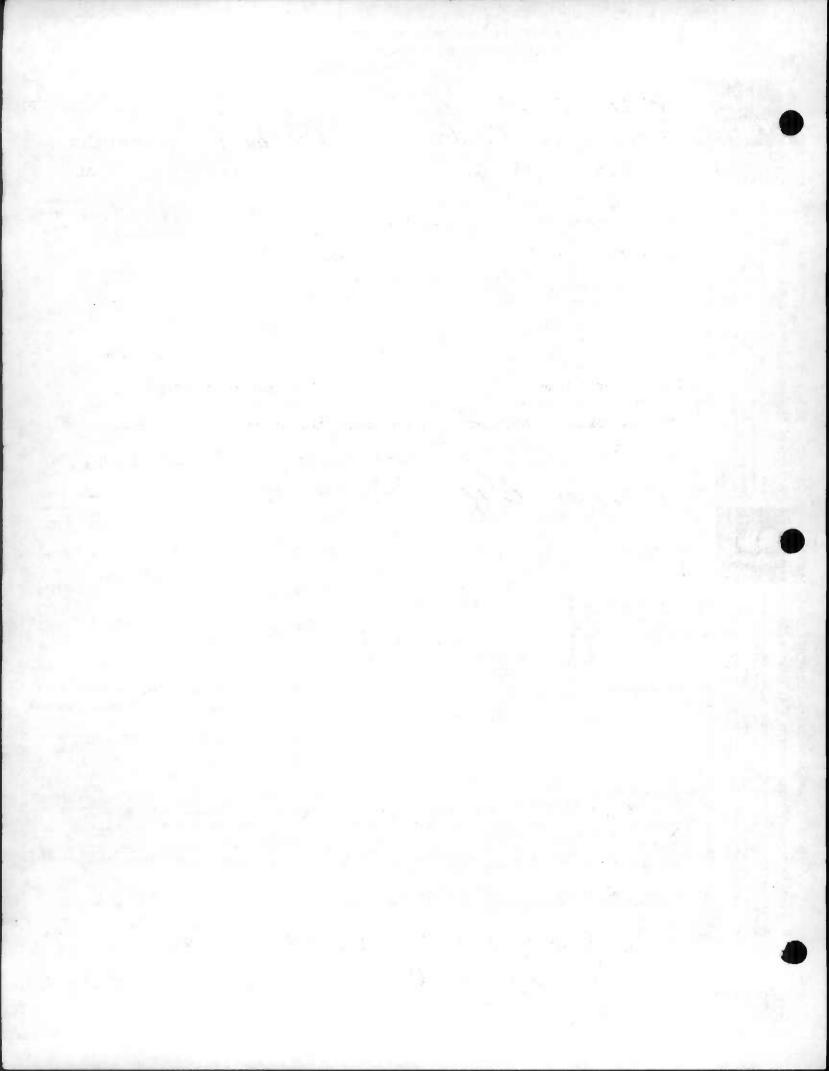


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				State of Ma		Department of Certificate of			jiene leg. No.	00	06340
Г	Physic	ian	1. Decedent's Name (First, Middle, Last)		FE			2. Date of Dee		Yeer	3. Time of Death
a.	/Med			ockle	1.00			Feb.	1	2000	9:20 a.m
	Exami	ner	4e. Facility Name (If not Institution, give	1 / 1	1		4b. City, Town, or	Location of Deeth	4c. Cou	nty of Deeth	4
_			5. Social Security Number 6. Sep	ed (e)		hdev) If Under 1 Year	If Under 24 Hrs	bury	WI	com	100
	Funeral Director			M 2XF 71	(In yrs. last birl	Yrs. Months Days				9. Birthp Coun	ece (State or Foreign try) Md.
	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examinet must be notified at		10e. Stete 10b. County		10c. City, Town	or Location				11	Od. Inside City Limits
	the Marylar 28a-f show	to	Md. Worceste	r	City				1 ☐ Yes 2♥ No		
	h the	Director	10e. Street end Number			10f. Zip Code			log. Citizen	of Whet Coun	try?
	th wi	alc	12106 Angler Road			218	342		USA		
	72 hours after death with the Maryla natural; or items 23a or 28a-f shouldes! Examiner must be notified at	Funeral	11. Maritai Status	12. Was Decedent Ex	ver in U,S.	13. Was Decedent of if Yes, specify Cut	Hispanic Origin? (S	specify Yes or No-	14. F	Race - Americ	
0	or it		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give		1 ☐ Yes 2 ☒ No		to Thour, otc./	Spe		HC.
00	72 hours natural',	d by	3 Widowed 4 □ Divorced	Year or Dates:			opconj.		Spe		ite
21215-0020	nation and a section	Completed	15. Decedent's Educ (Specify only highest grade	cation com <i>pleted)</i>	16a.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	petion during most of wo	rking	16b. Kind of	Business/Inc	lustry
12	filed within Hygiane. ther than out, the Mer	dm	Elementary/Secondary (0-12)	College (1-4or 5+	)		Đa)		20.5	-1	
	be filed within tall Hygiane. In other than event, the M		17. Father's Name (First, Middle, Last)			Florist	18 Mother's Na	me (First, Middle,		er Sho	P
an	Mental Merked o	o Be	John Walter Matth	ewc.							
Maryland	d 2 should but and Menta 7 is marked traumatic events	J.	19a. Informant's Neme/Relationship (Ty)		19b	Mailing Address (Stree		mily Whi			Codel
M	d2 than		Linda C. Skidmore		VIII. 17						0000)
ē,	-155		20a. Method of Disposition	, Daugneen	20b. Plece of	2106 Angler Disposition (Name of		Date Date		21842 n - City or To	wn, State
JO T	80 = 3		1 ☐ Burial 2 ☐ Cremetion 3 ☐ R. 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from State		y, cremetory or other ple Church Ceme		2-10-00	C	11111	V. 1
altimore,			21. Signature of Funeral Service Licanse	e A	Daces	22. Name end Addr		2-10-00	SHOW	Hill,	Md.
ä	permit. Departminporta		Dari M 40	111,	/	Short Fun		e, Inc.			
			23a. Part1. Enter the disease, or compli	cations that carry to	he death. Do n	13 E. Gro	We St De	almar Do	199	40	Approximate
	Physician		23a. Part1. Enter the disease, or compli- shock, or heart fellure. List only on	e cause on each line	double Do to	or or the mode of dy	ing, soon os cardio	di	betic		Approximete Intervat Between Onset and Deeth
	/Medical		tmmediete Ceuse (Finet	Food:	L 0.	1 Jan 1	cours		olas -	.61	LUPAKE
	Examiner		disease or condition resulting in death)	Enas	rage 1	renal di.	scase a	w to pu	map.	ary 6	years
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	the death certificate be executed y the attending physician and tched for use as the burial-transit	Examiner	Sequentially list conditions	. Type I	ue to (or as e c	onsequence of):	1700				4501)
ó	an ar		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Covers	YV AV	tery disea	10 , 20 1	a-lares	MALLAC	grd. D	several
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9	ng pt as ti	Med	resulting In deeth) Last	Reart	en:10	100	110110	de cong	estime	į	1000
Box	laath certifica attending pl d for usa as t	an	d	- nesi i	Duric	Ψ				- 1	
O.E	the ath	Physician/Med	Pert II. Other significent conditions con	tributing to death but	not resulting in	the underlying cause gi	ven in Part I.	23b. Did to	bacco uss	contributs to	the causs of death?
P.O.	that the de ed by the detached	Phy	Hypertension	H of	V./ 0	enne		1 U Y	88 2 N	3 Prob	ably 412 Unknown
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orc	v requires that been signed b should be deta	Completed	chronic ortical	Ribvillation	7, H. a	force in con	obrovasci	Ja 24a. Wes a perform		ava	re autopsy findings liebte prior to
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of	Physic this c	P	TE TES ZONO	ospital:		petient 3LI DOA		lome 5 Reside			)
L C	Affar Affar funan	on	27. Menner of Death  1 Naturel 5 Pending	28e. Dete of injury (Month, Dey	Year) 28b. T	jury Wo		28d. Describe h	ow injury occ	curred	
Sic	Attending in death.	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division of Vital Records,	or Attendated after dated Director:	Certification:	4 ☐ Homicide determined	28e. Pieca of Injun building, etc.		m, street, factory, office		281. Location (Si City or Town		m <i>ber or F</i> lurai	Route Number,
Ц.	plts and lined		20a Cartifica								
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) 2 Medical Examin	er: On the basis of e and manner state	xamination end	death occurred at the ti /or investigation, in my	me, date and pieca opinion, death occu	, end due to the corred et the time, d	ate end plec	menner as sto a, and due to	the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mainler state		29c. Licen	se number	2	9d. Date sin	ned (Month, L	Dev, Year)
	F 3 F 8		I your & He	var m.	0	DI	1002		2/7/0		
		-	30. Name end eddress of person who con	noleled cours of day	th (Itam 22a) C	(une Print)			/ / /		
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Registrar

FEB 0 8 2000 Benus G. Sparks



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Iva Fox Smith 2000 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY urity Number 6. Sex 17. Age (In yrs. last birthday) 11 Under 1 Year II Under 24 Hrs. 6. D. (No. 1) Months Deys Hours Min. WICOMICO 5. Social Security Number 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 25 F Yrs 224-38-8109 10-27-1904 PA Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Accomack Wattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 14. Race - American Indian, Bleck, White, etc. 7483 Wallops Millpond Rd. 23415 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐♠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Telephone Operator 8 Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest G. Fox Mollie Ball 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Wallace Smith 928 norfleet Rd. Virginia Beach, VA 23464 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBuriai 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rosewood Memorial Par2-7-00 Virginia Beach, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 7342 Lankford Hwy B.D. Holland Funeral Service Nassa 23a. Pert1. Enter the disease, or combications that caused the deeth shock, or heart failure. List only one cause on each line. Approximately a control of the deeth shock, or heart failure. List only one cause on each line. VA Nassawadox Approximate Intervei Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in death) racvanial Due to (or as e consequence of): Due to (or as a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): 00 1/ Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed?

**Physician** /Medical Examiner

20

permit. Pege Depertment of Important: If any Injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

by

Completed

Be

VA

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiene. Int: If Item 27 Is merked other than "natural", or Items 23

Baltimore, Maryland 21215-0020

the Meryland

ettending physician end for use es the buriel-transit thet the death certificate be executed the 98 Š bengis d be det peeu hes e 2 page certificate

Box 68760

P.O. I

Records,

Division of Vital

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical þ Completed Be Medical Certification: To

27. Menner of Deeth

29a. Certifier

1 Neturai

2 Accident 3 Suicide

4 ☐ HomicIde

29b. Signature and title of Cartifler

Alon

25. Was case referred to medical examiner?

1 Yes 2 No

6 Could not be determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospitel:

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Plece of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner steted.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Yes 2 No

mD dress of person who completed cause of death (Item 23e) (Type, Print)

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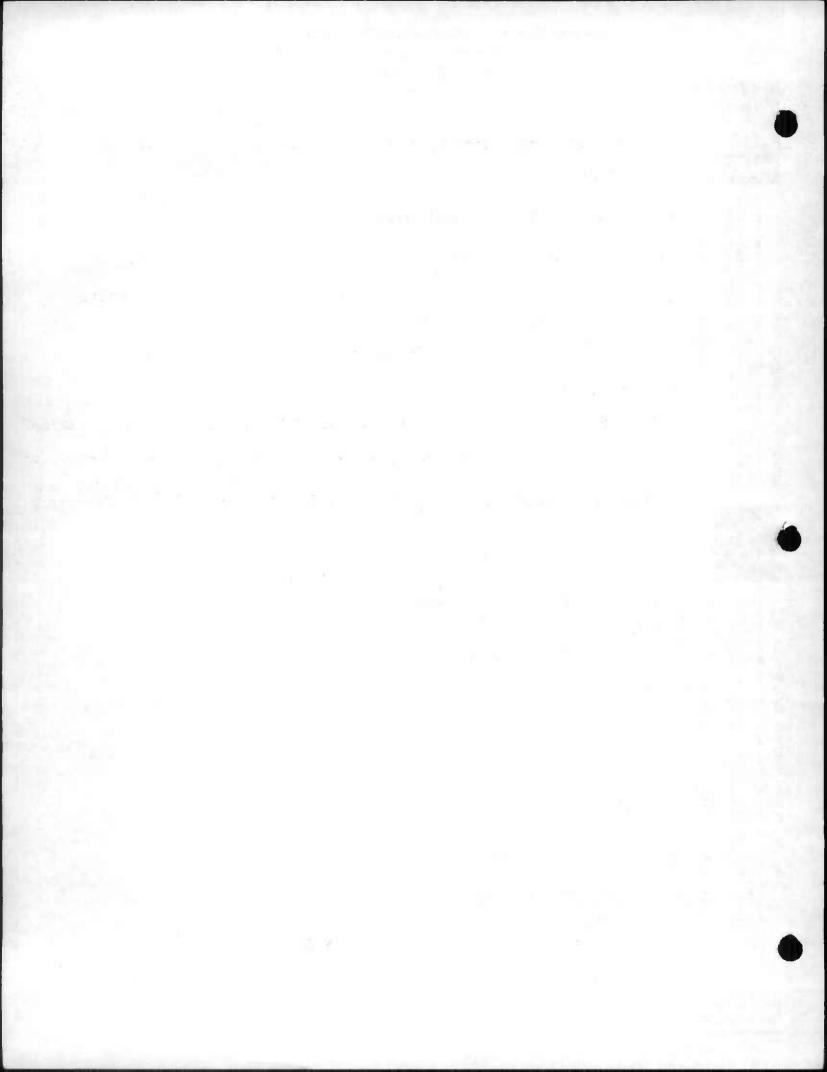
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29d. Dete signed (Month, Day, Year)

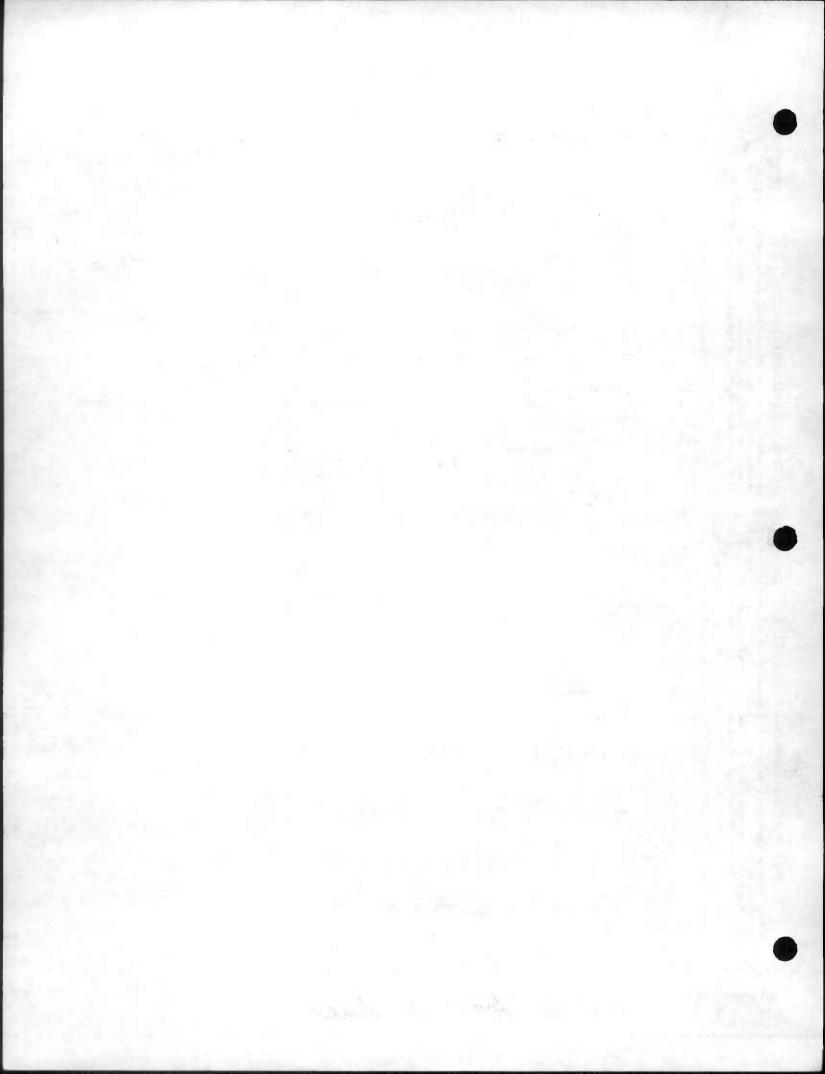
State Registrar 31. Date filed (Month, Day, Year) FEB 0 2000





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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** February 0932 Eula M. Shields 2000 /Medical 4a Facility Name (Il not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY Hours Min. 8 Date of Birth (Month, Day, Year)
May 23, 1924 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 219 F Director 244-38-2306
Usual Residence of Decedent 75 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Wicomico Salisbury or hams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6171 Westbury Drive Funeral 21801 U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? hours after 1 Yes 2 No if Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland 2121 filled within Elementary/Secondary (0-12) College (1-4or 5+) 9th elevator operator retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Brown Peterson, Sr. Sarah Quinn 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Peoples/daughter 6171 Westbury Drive, Salisbury, MD 21801 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 2/6/00 New Bern, NC 21. Signature of Euperal Service Licenses 22. Name end Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part Enter the disman, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, show, or haint feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical neumon u-Examiner Due to (or as a consequence of): Examiner physicien and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): been signed by the attending should be detached for use Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? Perpheral vascular dixin completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vital Physician: funeral director, 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 ☑ Netural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division or Attending 5 Pending 1 Yes 2 No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical completely (Check only one) ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DYITAI 102/00 mo 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) PAVLOS SALISBURY MO 21804 STEPHAN 400 E. SHORE DR. MO 31. Date filed (Month, Dey, Year) FEB 0 7 2000 32. Registrer's Signeture State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Daath 3. Time of Death Month **Physician** Walker Steele 23, 2000 January 0310 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin 123/00 60310 7. Age (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 10M 20 F Months Hours 82 241-14-1987 Director NC March 24, 1917 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified 1 XYes 2 No Directo Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21811 harms 23a 904 Decatur Apt. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarlcan Indian, 11. Maritai Status Biack, White, etc. 1 Navar Married 2 Married Specify: Black 6 1 Yes 2 No Specify: à 3 □Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 11th Laborer Construction Retailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) on and Mental b e 2 George Steele Delette Steele Pages 1 and 2 should STEELE 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Decatur Apt., Berlin, MD 21811 Separtment of Health important: If item 27 Lucille Steele/daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's UMC Cemetery 1/29/00 Berlin, MD 21. Signatura of Funeral Beretse 22. Name and Addrass of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Part I miler the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory and k, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician NEUMONIA /Medical immediate Causa (Finai disease or condition resulting in deeth) Examiner Examiner certificate be executed physicien end s the bunal-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medical Dua to (or as a consequence of): 980 ö 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. signed by t 3 Probably 4 ☐ Unknown 1 Yes 2 No by 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 TYes 2 No certificate i or Attending Physicien: after death. Director: After this certific director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menger of Deeth Dete of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation 1 Naturel injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 6 Could not ba determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 8 24 hours 1 Certifying Physictan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medicat Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) completely within 2 To the 29c. License number 29d Date signed (Month, Day, Year) 2000 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 29thway Dr BSRLIN 32. Register's Signeture 31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

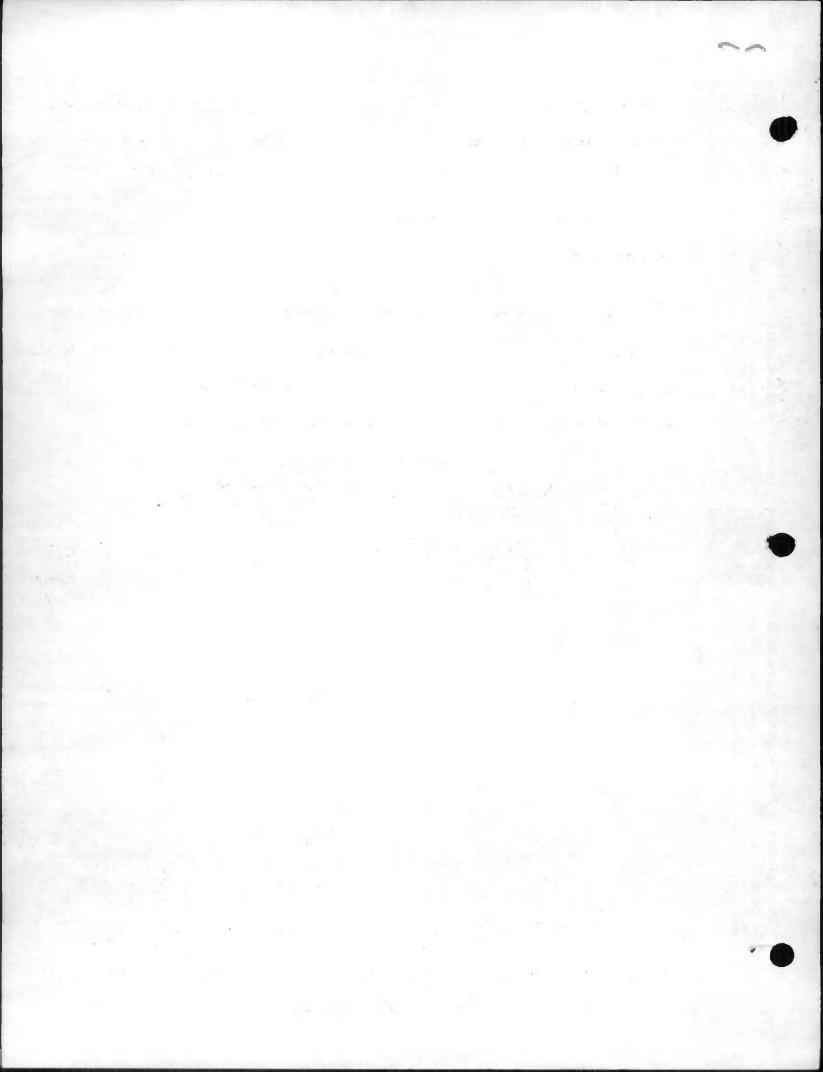
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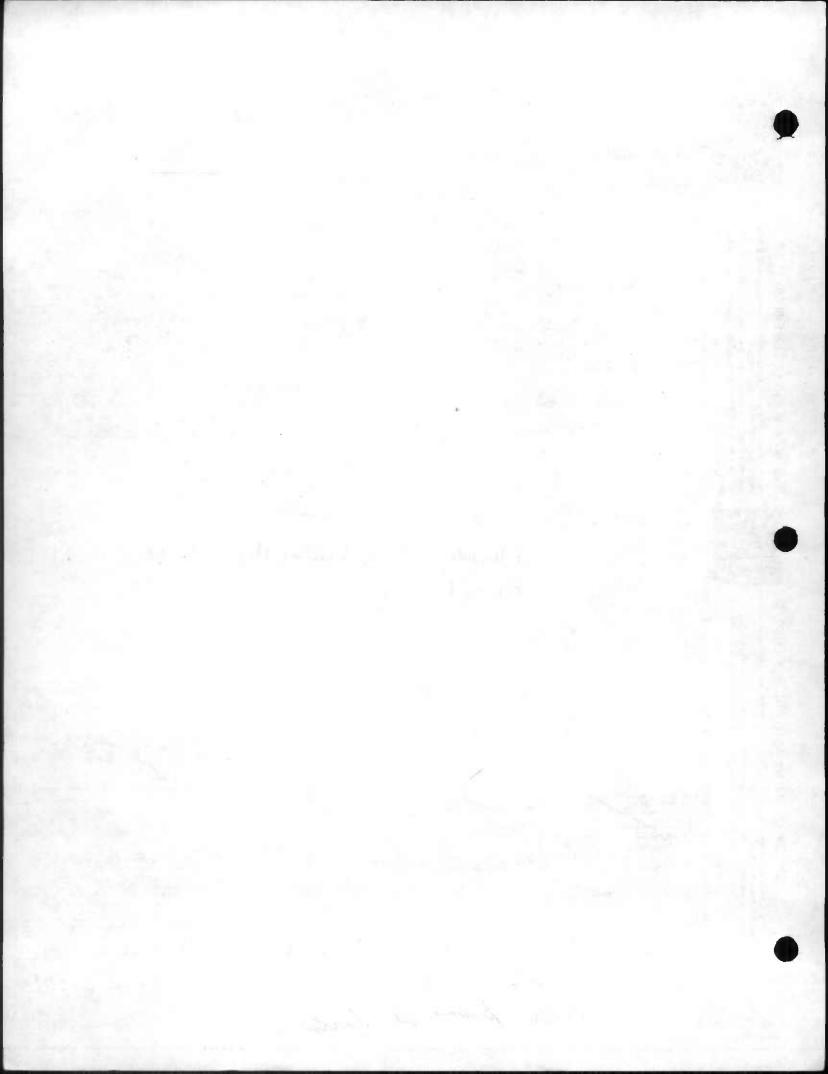
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5	Social Security N			ge (In yrs. las		If Under 1 Year	If Under 24		of Birth 1			State or Foreign
			1□M 20F		Yrs.	Months Days	Hours I	Vin. (Mon	th, Dey, Year)	00-	9. Birthplace (S Country)	note of 7 or org
U	n/a Isual Residence of	f Decedent						Jan	<del>30, 20</del>	00	MD	
-	Oa. State	10b. County		10c. City, 1	Town or Loca	ation					10d. Ins	ide City Limits
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10	0e. Street and Nur	mbor			-	10f. Zip Code			10a Ci	tizon of WA	hat Country?	
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11		n/a_	12. Wes Deceden Armed Forces	?	H Y	es Decedent of H res, specify Cubi	lispanic Origin an, Mexican, P	? (Specify Yes uerto Rican, et	or No-		<ul> <li>American Ind</li> <li>White, etc.</li> </ul>	en,
		ied 2 Merried	1 Yes 2 H	No n/a	10	Yes 25(No	Specify:			Specify:	Black	
	3 Widowed	4 □ Divorced	Year or Dates									
	(Spec	15. Decedent's city only highest of	Education grade completed)	1	16a. Decede (Give ki	nt's Usual Occup nd of work done O NOT use retired	ation during most of	working	16b. K	(ind of Bus	siness/Industry	
	Elementary/Secon		College (1-4or	5+)	life. DO	NOT use retired	d)					
	n/a					n/a					n/a	
17	7. Father's Name (	(First, Middle, La	st)				18. Mother's	Neme (First, A	Aiddle, Maider	Sumeme	)	
	Maurice	A. Smitl	h				Nina '	Y. Sava	ige			
1	9a. Informant's Ne	eme/Relationship	(Type, Print)		19b. Meiling	Address (Street	and Number of	r Rural Route	Number, City	or Town, S	Stete, Zip Code)	
N	Nina Y. S	Savage/mo	other		Rt. #:	2, Box 8	37B. Se.	lbvvill	e. DE	19975	5	
-	Da. Method of Disp			20b. Pled	e of Disposit	tion (Name of		Dete			City or Town, St	ate
			☐Removel from Stete	9		tory or other ple		2/4/0	1			
_		5 Other (Spec	-77	Green	-	s Mem Pa		2/4/0	o Sa	IISDU	ry, MD	
2	1. Signature of Fu	neral Service tic	enton	-	22. I	Name end Addre	watson	Funera	1 Home			
		1				618 West					)1	
2	3a. Pert1. Enter th	he disease, or co	mplications thet cause ly one cause on each	d the death.								el Between
Shi dCth re	iequentially list cor any, leading to im ause. Enter Unde ause (Disease or nat initiated events esulting in death) L	nditions, imediate whying injury Last	o. Pren	Due to (or es	s a conseque	nce or;						
	art II. Other eignif	Scent conditions	contributing to death	but not reculting	ag in the und	ladving cause gir	on in Part I	231	Did tobacco	a use cont	tribute to the c	ause of death
P	art II. Other eight	Name Containone	Continuous g to dout.	Dut 1101 16301til	ng m the one	onymig caose giv	on an Porci.	200	1 Yes 2		3 Probably	4 Onknov
Pa								_	10100 2	20140	O_ 1100etory	4 Contains
Pi								248	. Wes en euto	psy	24b. Were au	opsy findings
Pi									performed?			on of cause
Pi	1										of death?	
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P:									1 Yes 2	Dho	1 🗆 Yas	2□ No
	5. Was case referr	red to medical					26. Place of	Deeth (Check		100/10	1 🗆 Yas	2 No
	5. Was case referrence?		Hospitel: 1 Dinpat	ient 2 ER	VOutpatient	3□ DOA Oth	ner _	Deeth (Check	only one)			2 No
28	examiner? 1 Yes 2 1.  7. Manner of Death 1 Death	100	28a. Date of Ini (Month, D		VOutpatient 3b. Time of Injury	28c. Injur	ner: 4 Nursi	ng Home 5□	only one)	6 □Other	r (Specify)	2 No
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200	examiner?  1 Yes 2 Ju 7. Manney-0 Death 1 Wafatural 2 Accident 3 Suicide 4 Homicide  9a. Certifier (Check only)	5 Pending investigat 6 Could not determine	28a. Date of In (Month, D) 28e. Plece of In building, e	njury - At home	Bb. Time of Injury a, farm, stree	28c. Injun Word 1 Dot, factory, office	ner: 4 Nursi y et rk? Yes 2 No	28d. Des 28f. Loca City	only one) Residence cribe how injuition (Street e. or Town, Stet to the cause(s	6 Other	or (Specify) ad or or Rurel Rout	e Number,
21	examiner? 1	5 Pending investigat 6 Could not determine	28a. Date of In (Month, D be 28e. Plece of Ir building, e	njury - At home ofc. (Specify)	Bb. Time of Injury a, farm, stree	28c. Injury Wor M 1 1 control ot, factory, office	ner: 4 Nursii y et k? Yes 2 No me, date and p	28d. Des 28f. Loca City	only one) Residence cribe how injuition (Street e or Town, Stet to the cause(stime, date en	6 Other ory occurre ond Number e) s) and man	or (Specify) and or or Rurel Rout oner as stated, and due to the co	e Number,
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25 27 29	examiner? 1	5 Pending investigat 6 Could not determine	28a. Date of Ini (Month, D)  28a. Plece of Ini building, e  Physician: To the basis arminer: On the basis	ury year) 26 njury - At homoic. (Specify) t of my knowled of examination tated.	8b. Time of Injury e, farm, stree idge, death of a and/or inve	28c. Injur Wor 1 Dot, factory, office sccurred at the tir stigation, in my control 29c. Licens	ner: 4 Nursii yyet rk? Yes 2 No me, date and p ppinion, deeth o	28d. Des 28f. Loca City	only one) Residence cribe how injuition (Street e or Town, Stet to the cause(stime, date en	6 Other ory occurre ond Number e) s) and man	or (Specify) and or or Rurel Rout oner as stated, and due to the co	e Number,



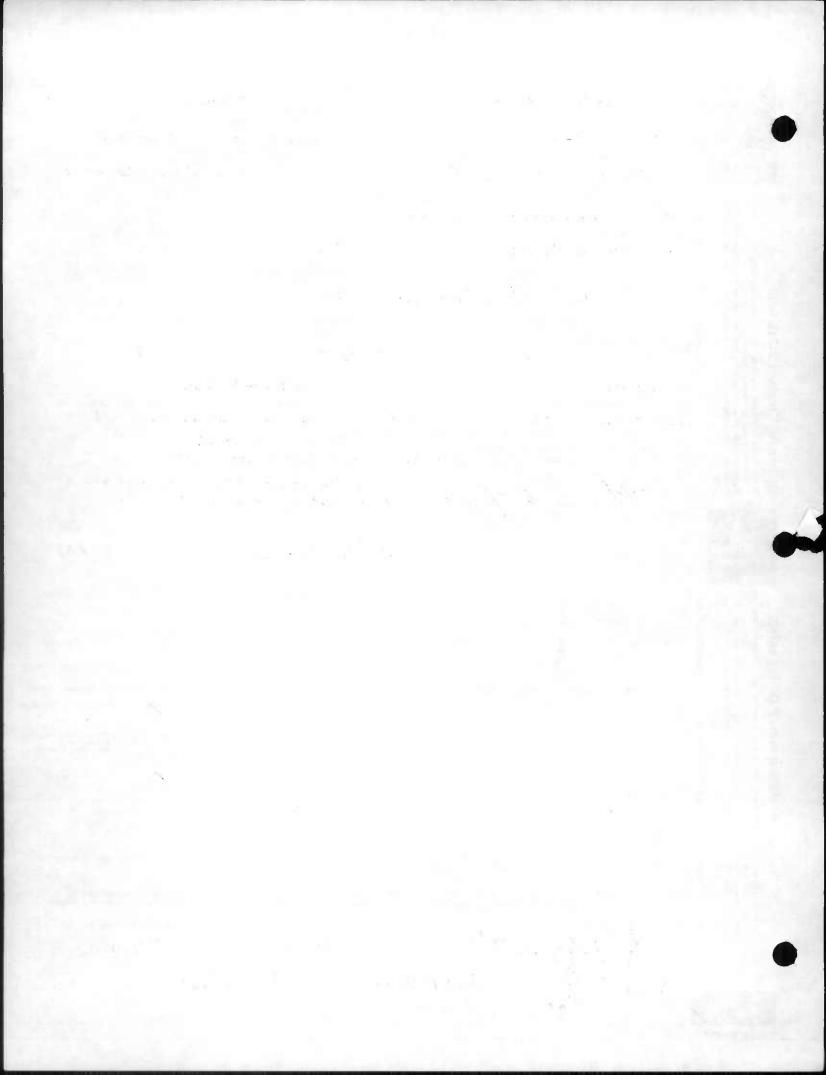
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) February 4, 2000 ear **Physician** 10:30PM Holland. James Strawn /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Heartland House Queen Anne's Grasonville 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours Yrs. 74 Jan. 3,1926 Tennessee Director 415-26-3579 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Manyland neat of Heelih and Mentel Hygleno. In this filem 27 is marked other than "natural", or items 23a or 28a-f ahow any or other traumatic avent, the Medical Examples must be notified at any or other traumatic avent, the Medical Examples must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Chester Oueen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21619 U.S.A. 35 F Queen Anne's Way Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 □ X/es 2 □ No
If Yes, Give
Yeer or Detes: 1953/1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Black, White, etc. 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) U.S. Navy 12 Oceanographer 18 Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Lula Mae Holland James Strawn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Pages 1 end 2 s Department of Heelth er Important: If itam 27 is any injury or other trau Barbara Strawn / Wife 35 F Oueen Anne's Way Chester, MD. 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 02/89/00 1 Removal from State 4 □ Donation 5 □ Other (Specify) Charlottesville, VA Monticello Memory Gardens, Inc. 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. bourn 106 Shamrock Road Chester, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Blather cancer Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed physician end s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 ettending p bed 23b. Did tobecco use contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be detech 1 Yes 2510 3 Probably 4 Unknown Division of Vital Records, p 24b. Were eutopsy findings evelleble prior to completion of ceuse of death? Completed 24a. Was an autopsy certificate hes t 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medicel exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Datural 1 Yes 2 No death. 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in b † Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Wrive Charles My 21619 prose 2108 D. Dorah 31. Date filed (Month, Day 32. Registrar's Signature State 9 2000

Registrar



Amended # 2 2/8/00 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Allegeny County State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 2000 Paar Day Month Physician MARGARET STRICKLAND FEB 1000 0948 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY 7. Aga (In yrs. last birthday) If Undar 1 Year It Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax **Funeral**  Birthplaca (Stata or Foreign Country) 1 M 2 F Yrs. 214-07-3534 85 Director 12,1914 VIRGINIA Usual Rasidanca of Decedant the Maryland 10a Stata r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Directo MARYLAND ALLEGANY CRESAPTOWN 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? P.O. BOX 5032 death 21505 12. Was Dacadant Evar in U,S. Armad Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Spacity: p Specify: WHITE 3 Widowad 4 □ Divorcad Completed 15. Decadant's Education (Specify only highast grada completed) 16a. Decadent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa ratirad) filed within 7 Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) permit. Pages 1 and 2 should be filled with Depertment of Health end Mental Hygien Important: If flom 27 is marked other that any injury or other trauments. DOWN TWISTER 12 FIBER 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be CHARLES LONGERBEAM SADIE ELLEN MCKENZIE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) JOHN STRICKLAND/SON 13003 6TH AVE., CRESAPTOWN, MD 21502
use of Disposition (Name of Law State Control of City or Town, State 20b. Place of Disposition (Nama of camafary, cramatory or other place) FEB 4,2000 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata REST LAWN MEMORIAL GARDENS | LAVALE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Sionatura of Funaral Sarvica Licansea 22. Nama and Addrass of Fecility HAFER CHAPEL OF THE HILLS MORTUARY 23a. Part1. Enter the discess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval interval interval. Approximata Intarval Batween Onsat and Death **Physician** Immediate Cause (Finel disaasa or condition rasulting in daath) /Medical Examiner Examiner Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in death) Last pue Dua to (or as a consequanca of): Records, P.O. Box 68760. ettending physician for use as the burie The lew requires that the deeth certificate be Physician/Medical Dua to (or as a consequence ot): signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably Unknown by Completed 24b. Ware eutopsy findings available prior to 24e. Wes en autopsy completion of cause of death? 1 Yas 2 No certificate 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; it Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

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29a Cartitier

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31. Data tilad (Month, Day, Yaar) FEB 0 8 2000

29b. Signatura and we at curtifier



DR. S. GUPTA, 625 KENT AVE., CUMBERLAND, MD 21502

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

19 Sports

Certifying Physician: To the bast of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end mannar as steled.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and mannar stated.

29c. Licensa number

733280

29d. Data signed (Month, Day, Year)

4 2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** Margaret E. Seib February 5 2000 01:50pm : /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Allegany Frostburg Village Adult Day Care Center If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foraign Country) **Funeral** Days 10 M 2 F Months 215-20-7123 Yrs. 06-May-25 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits ahow 10a Steta 10b. County 10c. City, Town or Location v 28a-f ahow 1 Yas 2 No Maryland Allegany Director **Frostburg** 10e. Street and Number 222 E. Main Street 10f. Zip Code 10g. Citizan of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours aftar death with Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23a or any Injury or other traumatic event, the Mexical Exprines must be a 21532-U.S.A. Funeral 12. Wes Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Biack, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specifylite by 35 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast greda completed) Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) Be William Eberly Nora Martin 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Mary Ann Riley Daughter Frostburg Marland 21532-222 E. Main Street Baltimore, 20e. Mathod of Disposition 20b. Piace of Disposition (Nama of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State State Veteran's Cemetery 09-Feb-00 Flintstone, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Run Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 John Approximata Interval Between Onset end Deeth 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical 1 month Immediate Ceuse (Final Syndrome Hepato-Renal disease or condition resulting in death) Examiner Examiner physiclen and the bunal-trensit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequance of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 80 esn Po signed by the e Pert it. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cirrhosis Liver Division of Vital Records, þ 24b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of ceusa of deeth? irector, page 2 s 1 Yes 2 NO 1 Yes 2 No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical lately filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only ona) Other: A Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et ' Work? 28d. Describe how Injury occurred 28b. Time of Naturei 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicida 28a. Plece of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) 4 Homicida 29a. Certifier The Cortifying Physician: To the best of my knowledga, daath occurred at the time, date and piece, and dua to the cause(s) and manner as stated. Medical complately (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. within 2 To the \$ 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certilier 0 3 ex 2000

State Registrar

31. Date filed (Month, Day, Year) FEB 0 7 2000

32. Registrar's Signature

S. T. Chang, M.D., Frostburg Plaza, Frostburg, Maryland 21532

30. Nama end addrass of person who complated causa of daath (Itam 23e) (Type, Print)

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Duist Francial Honse, St Fred Ave., Fostoria, MD 21532

at pang M.D. Foster i Real Hospital, Mandated 21532

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** DELLA MAE SHIPLEY /Medical 4b. City, Town, or Location of Death 2000 12:40 PM 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner LIONS MANOR NURSING HOME CUMBERLAND If Under 24 Hrs. | a r ALLEGANY If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 25XF Yes PA. Director 190-28-4699 FEB 8 1921 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1 Yes 2 No Director PA. BEDFORD CLEARFIELD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b RFD#3 15535 natural, or items 23s. U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: 1□ Yes 2□ No Specify Specify: þ 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) COOK 11 RESTAURANT-COOK 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 2 should be fi and Mental H is marked of 2 ROHM WIGFIELD JENNIE (UNKNOWN) permit. Pages 1 and 2 sh. Department of Heath and Important: If Item 27 is me. any injury or 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST E. SHIPLEY BOX# 211 FLINTSTONE, MARYLAND 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State FAIRVIEW CHRISTIAN CEMETERY FEB 4 2000 INGLESMITH, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final rotoruas wers diseasa or condition rasulting in death) Examiner Due to (or as a Examiner att words Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-tran Due to for as a consequence of neurog Physician/Medical Due to (or as a consequence for use as 20 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? the à 1 Yes 2 No 3 Probably 4 Unknown signed t P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 s Sec 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ACKNursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 1 Yes XX No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Aftert or Attanding 1 Natural 2 Accident 5 Pending Investigation n 24 hours after death. Ne Funeral Director: After pletely filled in by the fur 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida

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Registrar

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(Check only one)

RANJITHAN / 32. Registrar's Signaty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIONS MANOR NURSING HOME SETON DRIVE EXT. CUMBERLAND MARYLAND

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 2000

V.A.

29b. Signature and title of sentifier

altimore, Maryland 21215-0020

Box 68760

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Records,

Division of Vital

Hospital

To the Vithin 2 To the I complet

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

D 19750

29c. License number

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OPAL JANUARY 29, VIRGINIA 10:10 PM SHOWERS 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ALLEGANY COUNTY NURSING HOME CUMBERT AND ALLEGANY If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthdey) 5. Sociel Security Number Birthplace (Stata or Foraign Country) **Funeral** 1□M 2₽F Yrs 234-96-5083 87 Director WEST VIRGINIA DEC. 29,1912 Usual Residence of Decedent the Marylend 10a. State 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show X Yas 2 No MD ALLEGANY CUMBERLAND Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 400 GRAND AVENUE 21502 U.S.A. deeth Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status hours siter 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: WHITE þ 3 ₩idowed 4 Divorced Year or Dates: I Hygiene. other than "naturs ent, the Madical E Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast greda completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 8 7 is marked other trsumatic svent, 18. Mothar's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be 8 and Mental Pages 1 and 2 should be ment of Health and Menta ant: If item 27 is marked lury or other traumatic av JAMES PIERCE MARY ELIZABETH FEASTER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 400 GRAND AVENUE, CUMBERLAND, MD 21502 LYDA SWANDOL / DAUGHTER 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition No Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or page. 2/2/00 SUNSET MEMORIAL PARK CUMBERLAND, MD 21. Signeture of Funeral Service Licanses 22. Name end Address of Facility UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Between Onset and Death **Physician** Immediate Cause (Final /Medical YRS · CORDNAPY MIBRY disease or condition resulting in death) Examiner Due to (or es a consaquenca of) Examiner requires that the deeth certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physicien ar Box 68760. Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): ettending pl by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown à HEART CONGESTIVE þ Records, 24b. Wara eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? The law il director, page 2 s 2 No Division of Vital Physician: 25. Was case raferred to medical examiner? Be 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending F After 1 Matural 5 Pending investigation 1 Yas 2 No within 24 hours aftar deeth.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be datarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 | Homicide edical 29a. Cartifiar Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) end mannar as stated.

Medicat Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) (Check only one) and manner stated. 29b. Signature and title 29c. License number 29d. Data signed (Month, Dev. Year)

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State Registrar Robustiano J. Barrera, 600 Memorial Avenue, Cumberland, MD21502

31. Dete filed (Month, Day, Year)

See Registrar's Signature

Sports

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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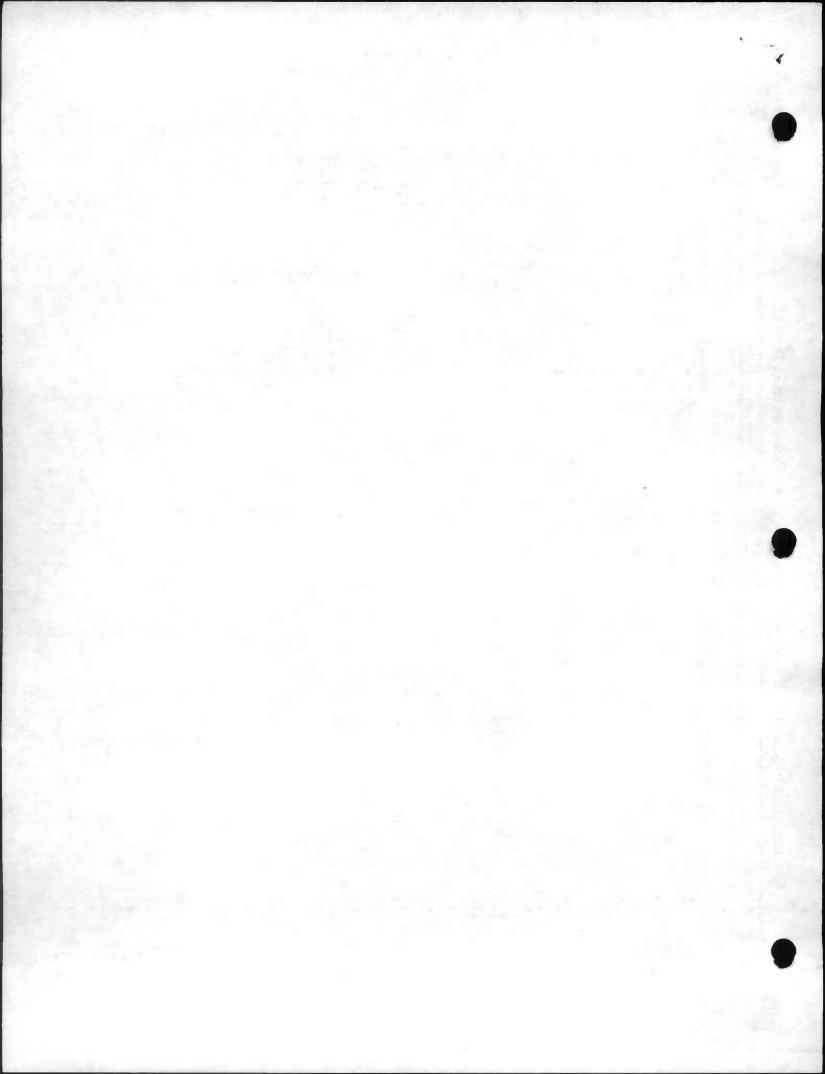
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State of Maryland / Department of Health and Mental Hygiene

			LAW SILE I	Certificate of			. No.					
	Physician /Medical	Decedent's Nama (First, Middla, La     CHARLES	THOMP:	SON		JANUARY	21, 20	000	3. Time of Death 2:00 PM			
	Examiner	4a Facility Name (If not institution, giv FREDERICK MEN		ral	4b. City, Town, or Loc FREDERI		4c. County FREI	of Death DERI	CK			
	Funeral Director		ex 7. Aga (fn yrs. I	est birthday) ff Under 1 Yas Months Dey	r If Undar 24 Hrs. s Hours Min.	8. Data of Birth (Month, Day, Y MAY 9,	°°° 1 937	9. Birthpl Count MD	lace (State or Foreign try)			
	the Maryland 28a-f show profiled at	Usual Rasidance of Decedant  10a. Stata  10b. County  MD FREDER		Town or Location				10	0d. Inside City Limits			
	D s o	MD. FREDER  10e. Street end Number  30 WEST ALL SA		101. Zip Code	1701	100	J. Citizen of V		try?			
020	by by	11. Meritel Stetus  1 Nevar Married 2 Married  3 Widowed 4 M Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas:	S. 13. Wes Decedent of If Yes, specify Cu	Hispenic Origin? (Spe ban, Maxican, Puarto F Specify:	cify Yes or No- Rican, atc.)	Blac	e - Amaric k, Whita, t BLA	atc.			
21215-	i within 72 liene. r than "nat ir omplete	15. Decedent's Et (Specify only highast gra Elementery/Secondary (0-12) 9 TH	Uucetion da complated) Collega (1-4or 5+)	16a. Decedent's Usual Occ (Giva kind of work don lifa. DO NOT use reti LABOR	upation a during most of workir red)	ng 16	CONS					
Maryland	ges 1 and 2 should be filed to theath and Mental Hygi if frem 27 la marked other or other traumatic event. To Be Co	17. Fathar's Nama (First, Middla, Last) WILLIAM ALFRE			18. Mother's Name BLANCH	(First, Middle, Ma IE FRED]						
	of 1 and 2 sho of Health and I frem 27 is ma other traums	19e. fnformant's Name/Relationship (ROGER THOMPSON	Type, Print) (BROTHER)	19b. Meiling Address (Stre 337 S. MA	et and Number or Rura RKET ST.	FREDER	City or Town,	Stata, Zip MD .	<sup>Coda)</sup> 21701			
Baltimore,	Peges 1. nent of He ant: if Item ury or oth	20a. Mathod of Disposition  1	Removal from Stata	ace of Disposition (Nama of ematery, crametory or other pRVIEW CEM.	JAN. 29	Deta 20 , 2000	FRED					
Balt	pemit. Pege Department of Important: If any injury or pace.	21. Signature of Funaral Service Liger	Pollis	rass of Facility ROLLINS F SOUTH SI			217	0.1				
S.	Physician /Medical Examiner  Examiner  Examiner	23a. Pan 1. Entar the diseasa, or comshock, or has traduce. List only Immediate Causa (Final disease or condition rasulting in deeth)	a. Left Dua to (or	as a consequence of):					Approximata fintarval Batween Onsat and Death			
	certificate be iding physicle ise as the bui	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that indicated evants rasulting in death) Last	с	as a consequence of):					7.3			
P.0.	The lew requires that the death also been signed by the atter page 2 should be detached for u. page 2 should by Physiciar Completed by Physiciar	Peri If. Other eignificant conditions of	ontributing to death but not result of the local with I	elting in the undarlying ceuse	given In Pert I.	23b. Did tobacco usa contribute to the cause of						
of Vital Records,	e lew requires that hes been signed t ge 2 should be det mpleted by P	thyroid				24e. Was en performe		ave	ara autopsy findings eilabla prior to mplation of ceusa daath?			
tal R	in: The lifticate ho or. page	25. Was casa refarred to medicef			26. Placa of Death		2 XNO	10	☐Yas 2☐ No			
ion of Vi	ing Physician: After this certific funeral director	examiner?  1 Yas 2 No  27. Mannar Death 1 A Netural 5 Pending 2 Accident Investigation	ma 5 ☐ Residan 28d. Dascribe how	ca 6 Oth		y)						
Ö	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmined	9 2	28f. Location (Stre City or Town,		er or Rura	il Routa Number,					
	To the Hospital within 24 hours. To the Funeral completely filled	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my know hiner: On the basis of examinet end manner stated.	est of my knowledga, daath occurrad at tha tima, data and plece, end due to tha causa(s) and mannar as stated. is of axamination and/or investigation, in my opinion, deeth occurred et the tima, date and place, end dua to tha causa(s) r stated.								
	To the comp	29b. Signetura end titla of celtifian	1	29c. Lice	nse number 21944	290	d. Dete signe	d (Month,	Day, Year)			
			MM made	300 W 9Th	· st.	Freder	ik,	md.	21701			
	State	31. Data filed (Month, Day Year)	32. Registrar's Signat	uia /	4							

Registrar



/Medical

Examiner

attending physician end for use as the buriel-trensit

deteched

signed by t

peed :

this certificate has rel director, page 2

within 24 hours effer deeth.

To the Funeral Director: Affer this certific completely filled in by the funerel director,

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by

Completed

Be

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Medical Certification:

Physician	1. Decedent's Nam	ne (First, Middle,	Last)		Thomas				2. Date of Death Month February	Dav	2000	3. Time of Deeth 8:00 A. M
/Medical					THOMas	5	_	4b. City, Town, or Lo				
xaminer	100	reek Cei	give street end numb nter	oer)				Annapolis			e Arun	
	5. Social Security 1 219-16-2		6. Sex 1 □ M 2 F 7	. Age (In yrs.		Months	1 Year Deys	Hours Min.	8. Date of Birth (Month, Dey, Nov. 3,	Year) 1923	9. Birth Cou Mar	plece (State or Foreigntry) 'yland
	Usuel Residence of	f Decedent										
72 hours after death with the Meryland ratural; or items 23s or 28s-f show real Examinar must be notified at steel by Funeral Director	10e. State	10b. County	1 o 1	10c. Ci	ty, Town or	Location thian						10d. Inside City Limit
	Maryland	Anne A	runder		LU			•		0::	****	
	10e. Street and Nu	ands Ro	ad			10f. Zip (		711	10	g. Citizen d	of Whet Cou	intry?
by Funeral	3 🖾 Widowed	ried 2 Marrie	12. Was Deced Armed Force  1  Yes 2 If Yes, Give Year or Det	es? Zano	J,S. 1:	3. Wes Decede If Yes, speci 1 Yes 2		Hispenic Origin? (Speban, Mexican, Puerto of Specify:	cify Yes or No- Rican, etc.)	В	ece - Amer leck, White cify: B1a	
etec	(Spe	15. Decedent's	Education grede completed)	t) 16e. Decedent's Usuel Occupetion (Give kind of work done during mos life. DO NOT use retired)				petion e during most of worki	ng 1	6b. Kind of	Business/I	ndustry
Completed	Elementery/Sec.	ondary (0-12)	College (1-4	lor 5+)		ator Op				edera	al Gov	vernment
	17. Fether's Neme	(First, Middle, Li	ast)					18. Mother's Neme	(First, Middle, M	eiden Sum	eme)	
To Be	Francis			Freela	nd			Mary		V	Mitti	ngton
	19e. Informent's N					ailing Address  9 Sands		et end Number or Rura oad Lothi	an, MD 2		vn, Stete, Z	ip Code)
	20e. Method of Dis	position	3 □Removal from St	ate	Plece of Dis cemetery, c	sposition (Nem remetory or of	e of her pl	aca)	Date 2	Oc. Locatio	n - City or T	own, Stete
any injury o	21. Signature of F			110	0	22. Name and	d Add	ress of Fecility S	Sewell	Fune	ral.I	Home -

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequenca of)

Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of):

Due to (or es a consequenca of)

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert II.

23b. Dtd tobacco use contribute to the causs of death? 3 Probably 4 Unknown 1 Yss 2 No

Decib, his ilce

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No

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25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 29 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work?

1 Anaturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

16 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the cause(s) end menner as steted.
2 Madicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner steted. 29e. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature andigitie of

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print). Or we Charles MD 21619 2000 31. Date filed (Month, Dey, Yeer)

State Registrar

1 0 2000 FEB

32, Registrer's Signeture

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month **Physician** Mattie (arpenter Truon ANUCKY 31, 2000 ion of Death 1605 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth Function, Day Year 909 9. Birthplaca (State or Foreign **Funeral** Days 10 M 25 F 274-10-6301 90 **Director** Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Salisbury 1 Yas 2 No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1514 Riverside Drive 21801 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 KINO 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager - Secretary 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Insurance Company 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ellen Bowen 17. Father's Nama (First, Middle, Last) Richard (arpenter 86 Mary 19a. Informant's Name/Relationship (Type, Print) NORA V. Nayworth (VLECE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if them 27 is any injury or other trac once. 2253 Par Road, Sebring, Florida 33872 20b. Place of Disposition (Name of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata John Taylor (enetery 1 MBurial 2 ☐ Cramation 3 ☐ Removal from Stafa 2-4-00 Temperanceville, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22 Stanger of une name Home Constance & & (hincoteague, Virginia 23336 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last sertension Oue to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown orgestion facture þ 24b. Wara autopsy findings available prior fo completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yas 2 No 1 Yas 2 No 25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

P.O. Box 68760. attending physician for use as the buna signed by the a Division of Vital Records. To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

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Pages 1 and 2 should be nent of Health and Mental

Department of

altimore, Maryland 21215-0020

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30. Name and address of person who completed cardie of death (Item 23a) (Type, Print)

10 State Registrar

31. Data fijed (Month, Day, Year)

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400 Easun Shire An 32. Registrar's Signature Depera

29c. License number D19289 29d. Data signed (Month, Day, Year)

Salisbury MD

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State of Maryland / Department of Health and Mental Hygien

Certificate of Death

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la	60	00	U	1	2)

Year

3. Time of Death

 Birthplace (State or Foreign Country) Delaware

10d. Inside City Limits 1 ☐ Yes 2 No

SEVEN HOURS

TWO DAYS

SEVEN manths

2211 PM

2. Date of Death

Month

1	/Medical	ADAM					TRAV	ATE	ELLO	JANUAR'	V 19 :	2000	2211 P
	Examiner	4a Facility Name (	If not institution	n, give street and n	umber)				4b. City, Town, or	Location of Deat	h 4c. Coun	ty of Death	
		THE JOHN	NS HOPK	INS HOSP	ITAL				BALTIMORE	CITY			
	Funeral Director	5. Social Security N 214-15-2	Section 1	6. Sex 1 M 2 □ F	7. Age (In	n yrs. last birth Y	day) If Unde Months	Days			ty, Year)		place (State or Foreigntry) Laware
	2	Usuat Residence of										1	
	with the Maryland a or 28a-f show the notified at	Maryland	10b. County Wico		10	Sali	sbury						10d. Inside City Limit 1 ☐ Yes 2 Ø N
	4 2 2 2 E	10e. Street and Nu	mber				10f. Zi	Code			10g. Citizen o	What Cou	ntry?
	th wit	27127 Pa	atriot	Drive				218	01		USA		
020	or home	11. Marital Status 1  Never Merr		ied Armed F	2½ No Sive	r in U,S.	13. Wes Dece If Yes, spe 1 Yes		Hispanic Origin? (Span, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	14. Ri Bi	ace - Ameri ack, White, illy: [V]	
00-19			15. Deceden	t's Education		16a. [	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of						ndustry
21215-0020		Elementary/Seco	ondary (0-12)	(1-4or 5+)		Give kind of wo life. DO NOT u	ork done ise retire	during most of wo	rking				
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Baltlmore,	permit. Pages 1 and 2 Department of Health a Important: if itsm 27 is eny Injury or other trei ance.	20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 □Removal from	n State	cemetery	Disposition (Na cremetory or o	other pla		Date 1/23/00	20c. Location		
Balt	Departri Importa eny Inju	21. Signature of Fu	unerat Service	Licensee	Om)	MOIOSI	Hollov	vay	ess of Facility Funeral H Hill Rd.,				ssociation
	Physician	23a. Part1. Enter t shock, or hea	the disease, or art failure. List						ing, such as cardia			2100	Approximate Interval Between Onset and Death
4	/Medical Examiner	Immediate Cause ( disease or condition resulting in death)	on	a. INT			HEMOR		AGE			10	seven Hour
4	p # sul			b. Col		OPATH	onsequence of)					i	TWO DAY
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00	= 24 =	regulting in death)	Last		Due	to for as 9 co	risequerice Of):						

To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the estanding phy completely filled in by the funeral director, page 2 should be detached for use as the Division of Vital Records, P.O. Box

by Physician/Med

Be Completed

Medical Certification: To

1. Decedent's Neme (First, Middle, Last)

Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

. ACUTE LYMPHOCYTIC LEUKEMIA

ACUTE RENAL FAILURE

ACUTE RESPIRATORY FAILURE

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yes 2 No 1 23 Yes 2 □ No 26. Place of Deeth (Check only one)

25. Was case referred to medical examiner? Hospitat: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20€No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Quittellitute, MD. January 19, 2000 D0055471

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

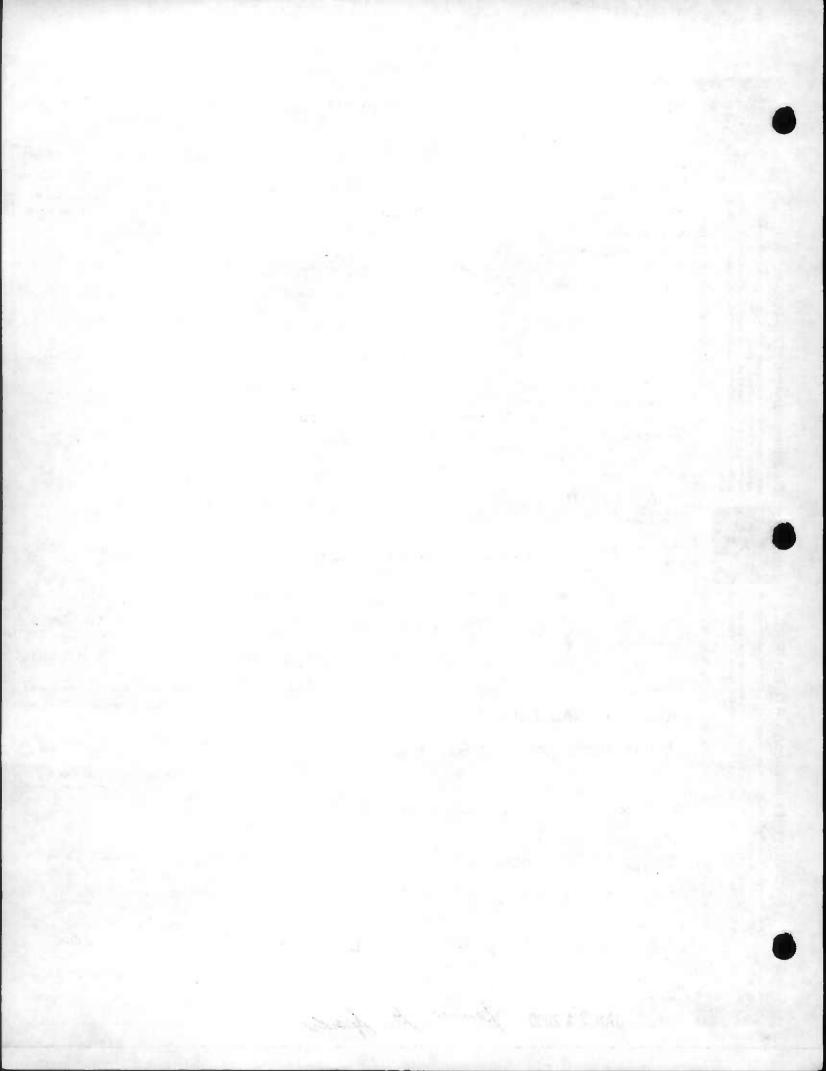
600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 R JEANETTE 31. Date filed (Month, Day, Year)

State Registrar

JAN 24 2000

32. Registrar's Signature

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		State c	of Maryl		epartmen Certificat			nd N	vlental Hy	ygiene Reg. No		0 0	36354
Decedent's Nama (First, Mary		Cather		Tal	bler				2. Date of Do Month FEBRU	Death Day		Year 00	3. Time of Death  10:35 AM
4a Facility Name (If not instit							Cumbe	erla		th 4c.	. County o		legany
5. Social Security Number  214-16-277  Usual Residence of Deceder		Sex 1 M 2 F	7. Age (In )	yrs. last birth	Months	or 1 Year Days		24 Hrs. Min.		irth lay, Year)	1912	9. Birthpla Countr	ace (Stata or Foreign
10a. State 10b. Co	ounty		10c	c. City, Town					- 19			100	ld. Inside City Limits
10e. Street and Number		egany		(	Cumber 10f. Zip	lan						hat Countr	A
Rte 8 Box 11. Marital Status	17-K	12. Was Dec	cedent Ever i	in U,S.	13. Wes Dece	adent of	215 Hispanic Origi		pecify Yes or Neto Rican, etc.)			- America	
1 Nevar Married 2 3 Widowed 4 Divo	144.30	1 Yes If Yes, Gir Year or D	2 No		If Yes, special Yes	1. 4		Puerro	) Hican, etc.,			white, et	
(Specify only hi		ade completed)	) (1-4or 5+)	9	Decedent's Usua (Give kind of wo life. DO NOT us	ork done use retire	e during most ( ed)					siness/Indu	Market No.
12 17. Father's Name (First, Mid				ret	tired	die	18. Mother	r's Nam	me (First, Middle	lle, Maiden	sing Sumame		ie
William J.  19a. Informant's Neme/Relat Frederick	ationship (T	Type, Print)			Mailing Address			r or Rui				State, Zip C	Code)
205. Outland of Disposition  1 Burial 2 Cramat 4 Donation 5 Other	ation 3 0	Ramoval from	State 20	Ob. Plece of D	Disposition (Nary, crematory or o	oria oria oria oria oria oria	ace)  1 Par ess of Facility 11 Fu	k	Date  2/09/ ral Ho	Cur	mber		
23a. Part1. Entar the diseas shock, or heart failure.	se, or come	pications that one couse on	caused the c	death. Do no					ryland		1502	1 1	Approximate Intervat Between Onset and Death
Immediate Cause (Finat disease or condition resulting in deeth)		a	1 1	UMA to (or es a co	onsequence of):	):						1 1	48 hrs.
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		b			onsequence of):								
resulting in death) Last	L	d											
Pert II. Other algnificant con	nditiona co	ontributing to de	eath but not	resulting In 1	the underlying o	ceuse gi	ven in Pert f.				/		the cause of death?
Dieber	ls	meli	litus		1					as an auto rlormed?	psy	avai	re autopsy findings ilable prior to appletion of cause leath?
Senil	le c	Den	ent	ia					10	Yes 2	2 DNo		Yes 2 No
25. Was case referred to me examiner? 1 ☐ Yas 2 ☑ No	-	Hospitai:	Inpatient 2	2 ER/Outp	patient 3 DC	OA OI	thor		eth <i>(Check only</i> forme 5 Res		6 □Othe	ar (Specify,	)
	ending envastigation		of Injury oth, Day Year	28b. Tin	ime of jury	28c. fnju Wo	ury at ork? ]Yes 2 □ N	No	28d. Describe	a how inju	ry occurre	be	

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examinei

Examiner Be Completed by Physician/Medical

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To

The lew requires that the death certificate be exec To the Hospital or Attending Physician: The within 24 hours after deeth.

To the Funeral Director: After this certificate t

Division of Vital Records, P.O. Box 68760,

wy

6

Registrar

CHANG OND 31. Dete filed (Month, Day, Year) State FEB 0 8 2000

29b. Signature and title of certifiar

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one) 6 Could not be determined

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

**Funeral** 

Director

"natural", or hems 23s or 23s-f show

permit. Pages 1 and 2 abould be lited within 72 hours atter. Department of Health and Mental Hygiere, Important: If Item 27 is marked other than "natural" or in-

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

with the Maryland

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

10701 New George Creek S.W Suit 3 Frostburg Marylang 21532 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**DHMH 16 Rev 6/95** 

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Alfred Slocum Vai1 February 4, 2000 10:35 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Months 1**X** M 2□ F Director 191-18-0709 Sep 25, 1916 Pennsylvania Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1♥ Yes 2 No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 261 Providence Circle 21793 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1X2 Yes 2 No It Yes, Give Yeer or Detes: 1946-47 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mentel Hygiene. Important; if item 27 Is marked other than "natural", or item any injury or other traumatic event, tra Medical Exercited page. Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Engineer Mechanical & Aerospace 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Alfred Montgomery Vail Phebe Adele Slocum 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1150 Park Ave., Apt 7F, New York, New York 10128 ce of Disposition (Name of Date 20c. Location - City or Town, Stete Stephen Vail, son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Donetion 5 Other (Specify) 2/7/00 Smithsburg, Maryland Smithsburg Crematory 21. Signeture of Fineral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701 M00999 23a. Pert1. Ent. the diseese, or complications that shock, or heart failure. List only one ceuselon caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical 5 days PNEUMOWIA Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ALUTE MEDCLESIA INFARCTION à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? METASTATIC PROSTATE CANCOR 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of oe 29c. License number 29d. Date signed (Month, Day, Year) D32171

State Registrar

the Maryland

21215-0020

Baitimore, Maryland

Box 68760,

P.O. 1

of Vital Records,

Division

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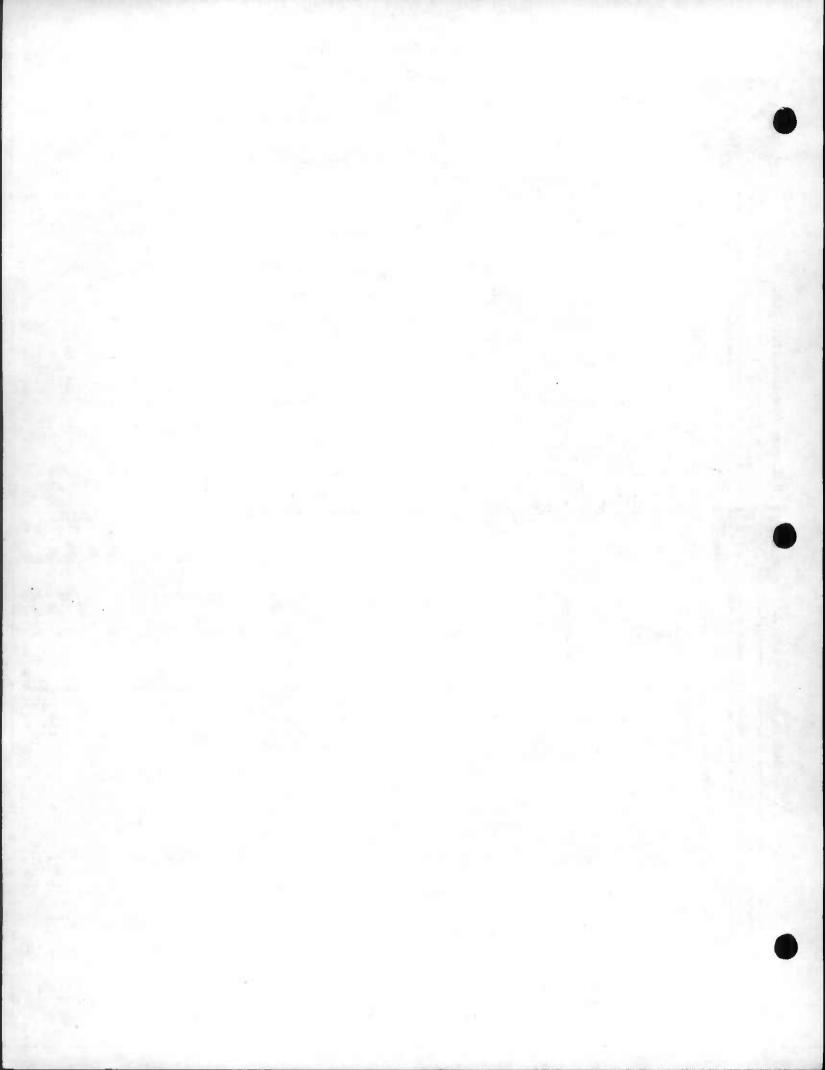
. Registrer's Signature

WALKORSVILLE MO

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

RICUARD GUIGH

31. Dete tiled (Month, Day FEB 0 7 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Year Month VELTEN CLIFFORD JAN. aa, 3000 3:00 PM 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death LIVING SALISBURY WICOMICO ASSISTED If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 6. Sex 1M M 2□ F Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 90 Yrs. 097-09-9678 AUG. 27, 1909 STATEN ISL., NY Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inalde City Limits 1 Yes 2 □ No MD. SALISBURY WICOMICO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 DRIVE USA 1110 HEALTHWAY 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 FIRE NYC FIRE DEPT. FIGHTER 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme) CLIFFORD O. VELTEN FLORENCE E. DIXON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 LINKS LANE CLIFFORD R. ANDERSON EXECUTOR BERLIN, M.D. 21811 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State Burial 2 Cremation 3 Removal from Stete ROSEHILL LINDEN, NJ CREMATORY 1-25-00 21. Signin 22. Name and Address of Fecility e of Funeral Service Licenses M01051 HOLLOWAY FUNERAL HOME, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause of each line. SALISBURY. MD. 21804 Approximete Interval Between Onset end Death Immediate Cause (Final diseese or condition resulting in death) Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hematoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yea 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

ettending physician and for use as the burief-transit that the death certificate be axecuted Box 68760. signed by the e Division of Vital Records. law requires been si Is certificate has director, page 2 Physician: this funerel After or Attending deeth. within 24 hours after deeth To the Funeral Director: , complately filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

Show

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r than "naturel", or items 23a or 28a-f shorthe Medical Examiner must be notified at

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Department of Important: If any injury or

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Certification:

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29a. Certifier

altimore, Maryland 21215-0020

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homleide

25. Wes cese referred to medical examiner?

5 Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and this or partition

29c. License number partal 29d. Date signed (Month, Day, Year)

Holenk, De 19944

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Ni Choley N.

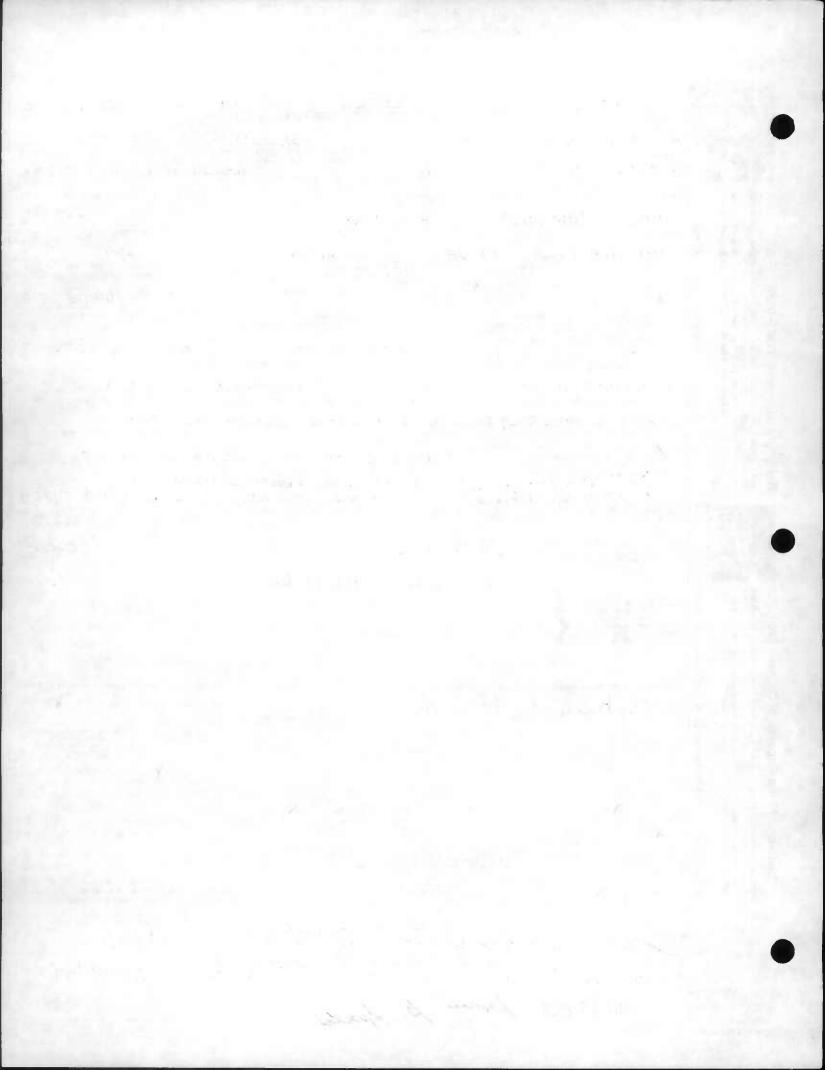
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32 Registrar's Signature

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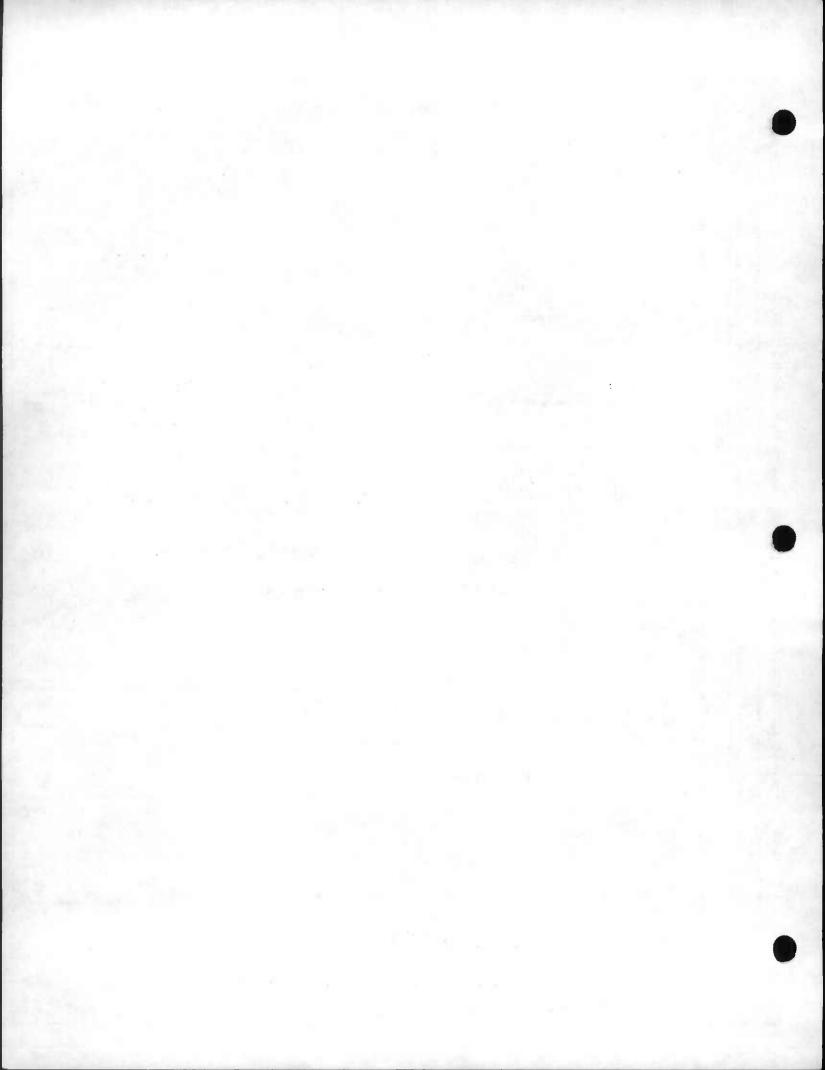
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 05357

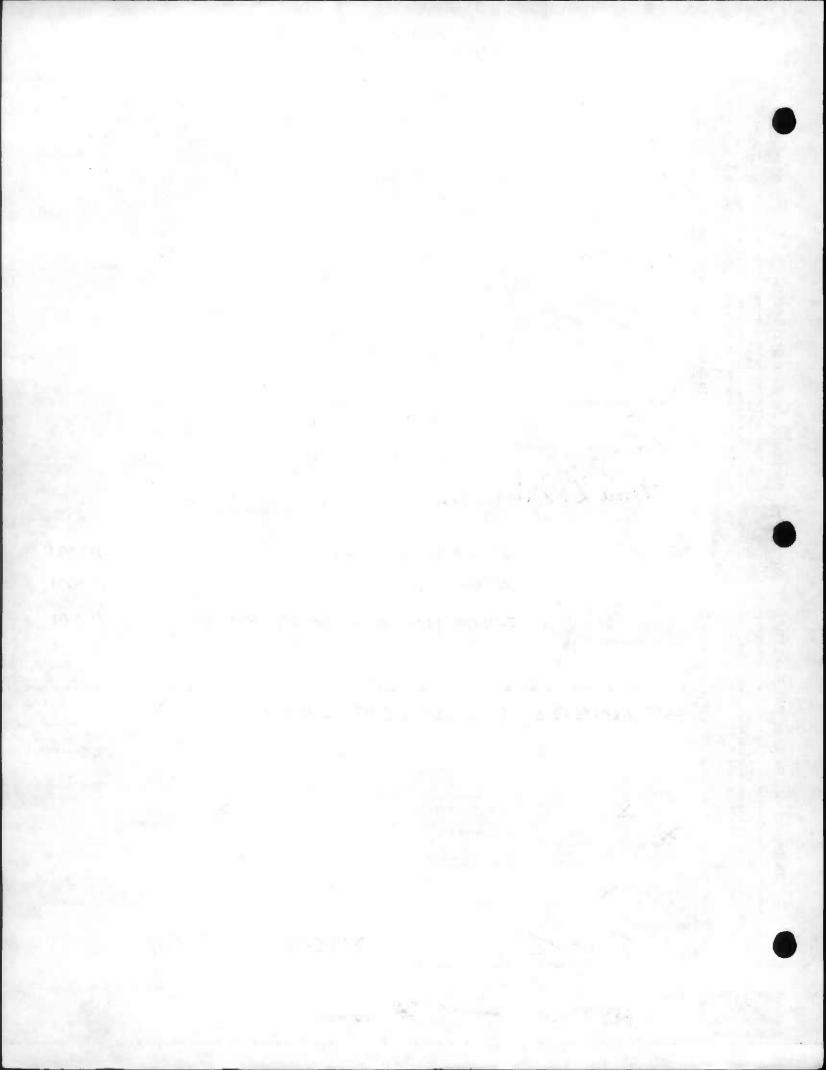
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Physician	1. Decedent's N	ame (First, Middle,	Last)					Month	Death Day	Year	3. Time of Deeti
/Medical		Robe						Janua	-	2000	8:00
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Funeral Director	5. Social Securit 212-42- Usual Residence	-1707	3. Sex 7. 1 □XM 2 □ F	Age (In yrs. i	Yrs.	If Under 1 Yea Months Day		viin. (Month,	Birth Day, Year) 12, 194	9. Birth Cou 15 Man	place (State or Fore intry) ryland
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or 20	10e. Street and	Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
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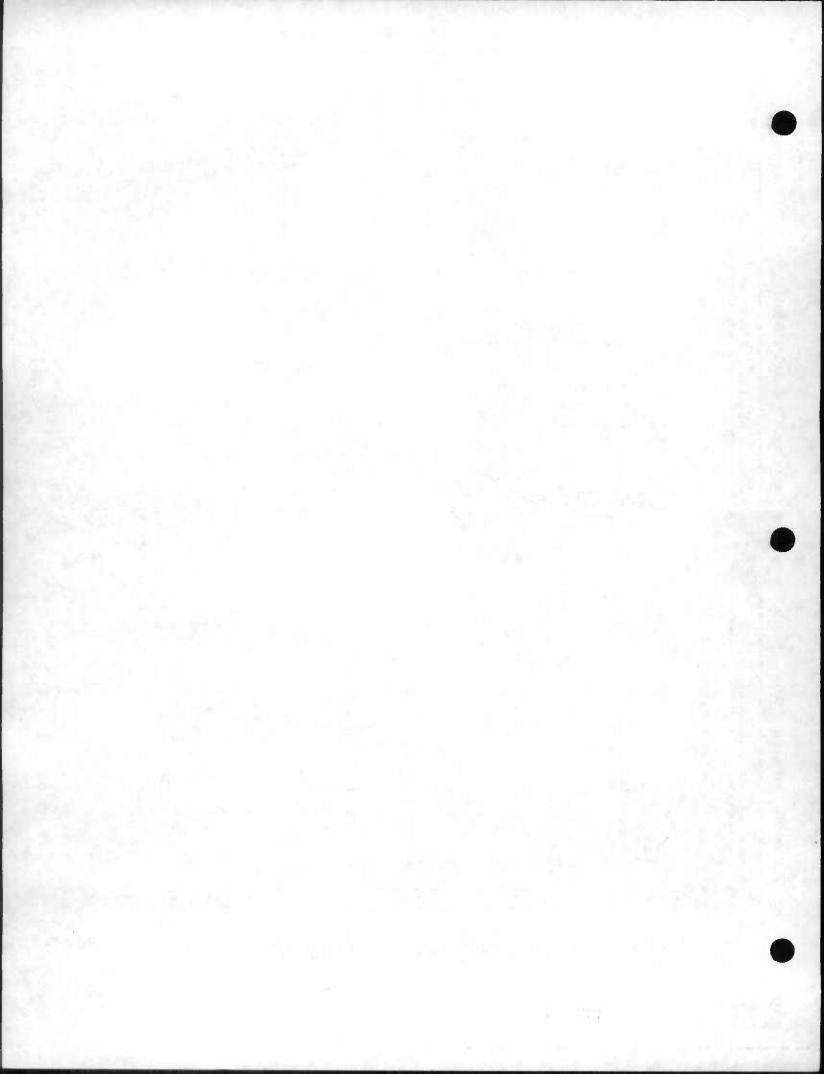


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A	Lamine	•	Gladys S	pe11man	n Nursing	Ho	me				Cheve				Prince	Geo	rge's
	Funeral Director	-	5. Social Security N 216-24-26	29	6. Sex 1 ☑ M 2 ☐ F	7. Age	e (In yrs. lest 73	birthday) Yrs.	if Under 1 Months	Year Deys	Hours N	Min.	8. Date of (Month) Aug.	Dey,			place (State or Foreign ntry) ryland
П	land ww	- 1-	Usual Residence of 10a. State	Decedent 10b. County			10c. City, To	own or Lo	ocation							1	0d. Inside City Limits
	Mary and and	1010	Maryland	Cal	lvert		P	ort	Repub1	ic							1 ☐ Yes 2 📉 No
	or 28	Directo	10e. Street and Nur						10f. Zip C		3330			10	g. Citizen of V		ntry?
	is 23a		1940 Pa	rkers	Creek Roa		Ever in IIS	13	Was Decede	206		2 (Snev	ify Ves or	No-	US 14 Bacı		can Indian,
Maryland 21215-0020	urs a	DA LOL	1 Never Marri 3 Widowed		ied Armed I	Forces? 2 D N Sive	1946 1947	_	If Yes, specif		lispanic Origin' an, Mexican, Pi Specify:	uerto F	licen, etc.	140-	Blac	k, White, Bla	etc.
5-0	n 72 hours natural',	Completed	(Spec	15. Decedent	l's Education st grade completed	1)	16	6a. Dece (Give	dent's Usual kind of work	Occup done	ation during most of d)	workin	g	1	6b. Kind of Bu	siness/în	dustry
121	within ene. than	ф	Elementary/Seco	ndary (0-12)	Coilege	(1-4or 5	i+)		<i>bo Not use</i> Carpent		3)				Const	ruct	ion
Dd 2	単工を言	200	17. Father's Neme (	(First, Middle,	Last)						18. Mother's	Name	(First, Mic	idie, M	eiden Sumem	e)	
ylar	0 2 7 0	0	John	Cepl	has	W	allace				Hatti	e			Commo	dore	
Mar	and and is m		19a. Informant's Na								end Number o						
	t Haalth fem 27 other tr	-	Bertha Wa 20a. Method of Disp		Wife		20b. Place	of Dispo	osition (Neme	e of		Koa	Date	-	Oc. Location -		MD 20676 own, State
mor	Pages nant of nt: If its iry or o			Cremation	3 □Removal from	n State	ceme	etery, cre.	metory or oth	ner pled	emetery	2/					ic, MD
Baltimore,	permit. Pages Department of Important: If I any injury or pnce.		21. Signature of Fu	neral Service		0			2. Name and						ral Ho		MD 20678
	1000	+	23a. Part1. Enter the shock, or heal				the death. D									Tek	Approximale Interval Between
	Physician /Medicai Examiner	<u>.</u>	Immediate Cause ( disease or condition resulting in death)	Final				uji	· C		ncer				,	2	Monshift Monshift
x 68760,	ficate be physicials the bur	3	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initieted events resulting in death) L		c		Due to (or as										
Box.	the attending hed for use a	rinysicialium	Part II. Other signifi	leant conditio	ne contributing to	death hi	ut not reculting	g in the u	Inderlying cal	use niv	ren in Part I		23h I	Did tob	180 CO 1180 CO	atribute t	o the cause of death?
P.0	t the by th	1193	raitii. Ottor algiini	icam congrio	ns contributing to	uoatii bt	at not resulting	g in the t	indenying car	ase giv	or are are a				2 □ No		
	igner igner	2										_					
Records,	been sign		NAME OF											Vas an erform	autopsy ed?	av	ere autopsy findings vailable prior to empletion of cause
Rec	The law ate has b	paraidillos												☐ Yes	2 No		déath? □ Yes 2 □ No
Vital	certificate		25. Was cese refer	red to medicel							26. Place of	Death					1 162 2 NO
of Vi	Physician: this certific ral director,		examiner?	10	Hospital:	] Inpatie	nt 2 ER/	Outpatie	nt 3 DOA	Oth	or.				nce 6 Doth	er (Specia	(y)
o u	ding Pt h. After th funera	-	27. Menner of Deeth 1 Naturel	5 Pendin	9	e of Injui	y Year) 28t	b. Time o		c. Injur Wor		2	8d. Descr	ibe hov	v Injury occurr	ed	
Division	Attending ar death. ector: Afte by the fune	cer micanon.	2 ☐ Accident 3 ☐ Suicide	investig	not be 28e. Plac	ce of Inju	ury - At home,	, farm, st	M reet, factory,		Yes 2 □ No	2				er or Rur	el Route Number,
Ö	s aftar il Dire		4  Homicide	doteilli	buil	ding, etc	c. (Specify)						City or	Town,	State)		
		מוכפו	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physician: To the Examiner: On the and ma	basis of	examination	dge, deat and/or In	h occurred at vestigation, i	t the tir in my o	ne, date and p pinion, death o	lace, a occurre	nd due to d at the ti	the cei me, da	use(s) and ma te and place, a	nner es s and due t	stated. o the cause(s)
	within To the	-	29b. Signature and	title of certifier	ukohi	M.	1		29c	Licens	e number	8		29	d. Date signed	(Month,	Day, Year)
			30. Name and addre	essol person	1 .	use of de	eath (Item 23	a) (Type,	Print)	ل	Que	7	M	1	20	78	5
	State Registra		31. Date filed (Mont		Sener.	Registre	er's Signature	b	n. V		C						

and the second ^ . ATTACH ATTACHED HINT THE THEFT AND AND AND THE Electron en Elitherman en maria de AND THE THE STATE OF THE STATE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** James Otis Williams Feb 07 2000 1046 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (tf not institution, giva street and number) Examiner Fruitland 316 Dulany Avenue Wicomico 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Deys Months Hours 10 M 2 F Yrs. 227-72-6286 55 Director March 3, 1944 Usual Residence of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Maolcal Examinar must be notified at 1 ☑Yes 2 ☐ No Director Wicomico Fruitland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code daath with 316 Dulany Avenue 21826 U.S. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2≦ No If Yes, Giva 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours aftar 1 Never Married 2 Married 21215-0020 Black 1 ☐ Yes 2 ☐ No Specify: Specify: p 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within 7 Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 6th Laborer Manufacturing Pages 1 and 2 should be filed w ment of Health and Mental Hygian ant: If flam 27 Ia marked other th luny or other traumatic evant, the Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Mary Cave James Otis Williams 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Williams/mother 135 Boiling Spring Rd., Barnwell, SC 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or price. Union UMC Cemetery 2/12/00 Barnwell, SC 21. Signature of Puneral Service Lice 22. Nama and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 238. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death **Physician** /Medical Immediata Ceuse (Finel diseasa or condition rasulting in deeth) Sophaged Examined Examine the death certificate be axecuted attanding physician and for use as the burial-tran-Sequentially list conditions, if any, leeding to immediata causa. Enter Undarlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed

Box 68760, P.O. Records, of Vital this funarai Aftart I or Attending Patter death. Division

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edical Certification:

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Director:

To the Hospital within 24 hours a To the Funeral Completely filled

1 Yes 2 No 1 Yes 2 No 25. Was casa referred to medical examinar?
1 ☑ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Mennyer of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending invastigation 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicida 28e. Ptece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiar and mannar stated. 29d. Data signed (Month, Day, Year) 29c. License number

MO 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

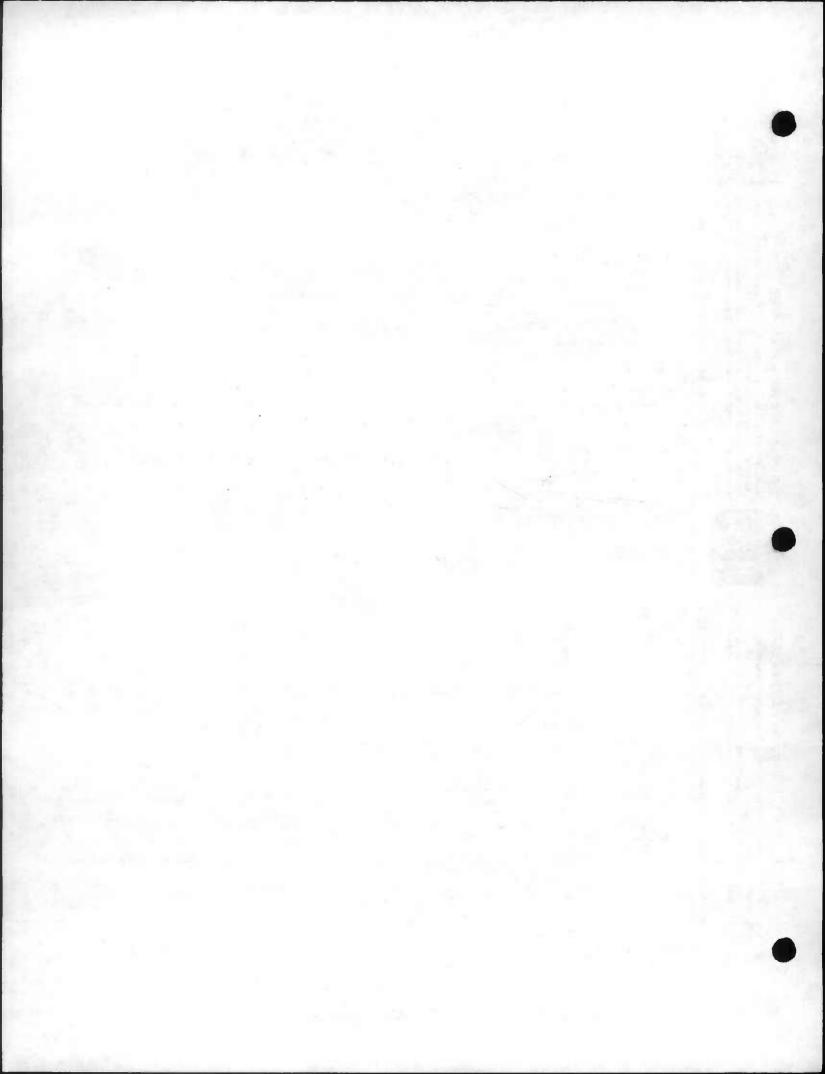
Rember Dr Suje 2A Scholing no 21801 JARUH MO exerne 1201 31. Data filed (Month, Day, Year)

State Registrar FEB 14 2000

29b. Signeture and title of certifier

32. Regisfrar's Signatura Deper

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			State of M	arylariu /		rtificate o				Rag. No.	UU	06362
unini		1. Decedent's Neme (First, Middle, Le	st)						2. Dete of Dee	eth Dey	Yaer	3. Tima of Deeth
ysici: /ledic		ROBERT WALLER							1	29	00	1022
amin	er	4e. Facility Neme (If not institution, give	wn, or Lo	cation of Deeth	4c. County of Deet							
	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO  5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthbole											
erai ctor			M 2□ F	50	Yrs.	Months Dey		Min.	8. Date of Birtl (Month, Da) 10–16–4		9. Birthpi Coun Mar	lece (State or Foreig try) yland
-		10e. Stete 10b. County		10c. City, To	wn or Lo	ocation					T10	Od. inside City Limit
Pa	tor	Maryland Wico					1 X Yes 2 □ N					
If be not	i Directo	10e. Street end Number 613 Manor Drive				10f. Zip Code 2180				10g. Citizen of USA	of Whet Country?	
event, tre Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Nevar Married 2 ☐ Marriad  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedant Armed Forces? 1 ☐ Yas 2 ☑ If Yes, Give Yeer or Dates:			Was Decedent of If Yas, specify Co 1 ☐ Yes 2 ☑ N			14. Re Bl	ace - Amaric ack, White, o	etc.	
100	Completed	15. Decedent's Ed		16	ie. Deced	dent's Usuel Occ	upetion	4 m 6 mm mlni		16b. Kind of	Businass/Ind	lustry
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2			OMM		Sal	les mana						Condition
	To Be	17. Fether's Neme (First, Middle, Last, Roger L. Waller							(First, Middle, Whaley	Meiden Suma	ime)	
5		19e. Informent's Neme/Relationship (				City or Town, State, Zip Code)						
other traumatic		Brian R. Waller/S	on	20h Place		L Campgr		d., i				
any injury or other tr once.		20e. Method of Disposition 1   ☐ Buriel 2 ☐ Cremetion 3 ☐				netory or other p		1,	Date O	20c. Location		wn, Stete
		4 Donetion 5 Other (Specif		Sprir		l Memory C			2/2/00	Hebron	, MD	
ouce		21. Signatura of Funeral Service Licer	TA MC	1051	H	Nama and Add Holloway	Funera	al H				sociatio
s me our	Medical Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in daath) Last	b	Due to (or es	e conseq	quence of):						
	Physician/M											
	iysic	Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.								obacco use c	ontribute to	the cause of deat
	by Pr								101	/es 2□ No	3X Prob	ably 4 Unkno
	Completed								24e. Wes a perfor		ava	re eutopsy finding illabla prior to npletion of cause death?
	Con								1□ Y	es 2X No	1 🗆	Yes 2□ No
	Be	25. Wes case referred to medical exeminer?	Hospital:						(Check only or			
	tion: To	27. Menner of Deeth  1 Natural 5 Pending 2 Accident investigation	28e. Dete of Inju		Outpetien Time of Injury	f 28c. In			me 5 Resid 28d. Describe h			)
	Certification:	3 Suicide 6 Could not be determined		ury - At home, c. (Specify)	farm, str	reet, fectory, offic	9		28f. Location (S City or Tow		nber or Rure	Routa Number,
	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of end menner sta	examinetion e	ge, death and/or inv	n occurred et the vestigation, In my	time, dete en opinion, deet	d piece, o	end due to the ded et the time, d	euse(s) end n date end piace	nenner es st e, end due to	eted. the ceuse(s)
	4									29d. Data sign	ed (Month, L	Dey, Year)
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		29b. Signature end titla of cartifiar	pulsalen	D	ME	D000	3599			1-29	9-00	
A SOCIAL STATE OF THE STATE OF		Signature end titla of cartifiar     Neme end address of person who JOHN T. BULKELE			) (Type,	Print)		Y,MD	. 2180		9-00	

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** SANDRA WILLEY VAN4ANY 28, 2000 0445 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year Months Days Hunder 24 Hrs. No. 1 B. Date of Birth (Month, Day, Year)
MARCH 20, 1955 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 2K F Hours 214-66-9437 Director MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinal must be notified at 1□ Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 2711 OLD OCEAN CITY RD 21804 U.S.A.

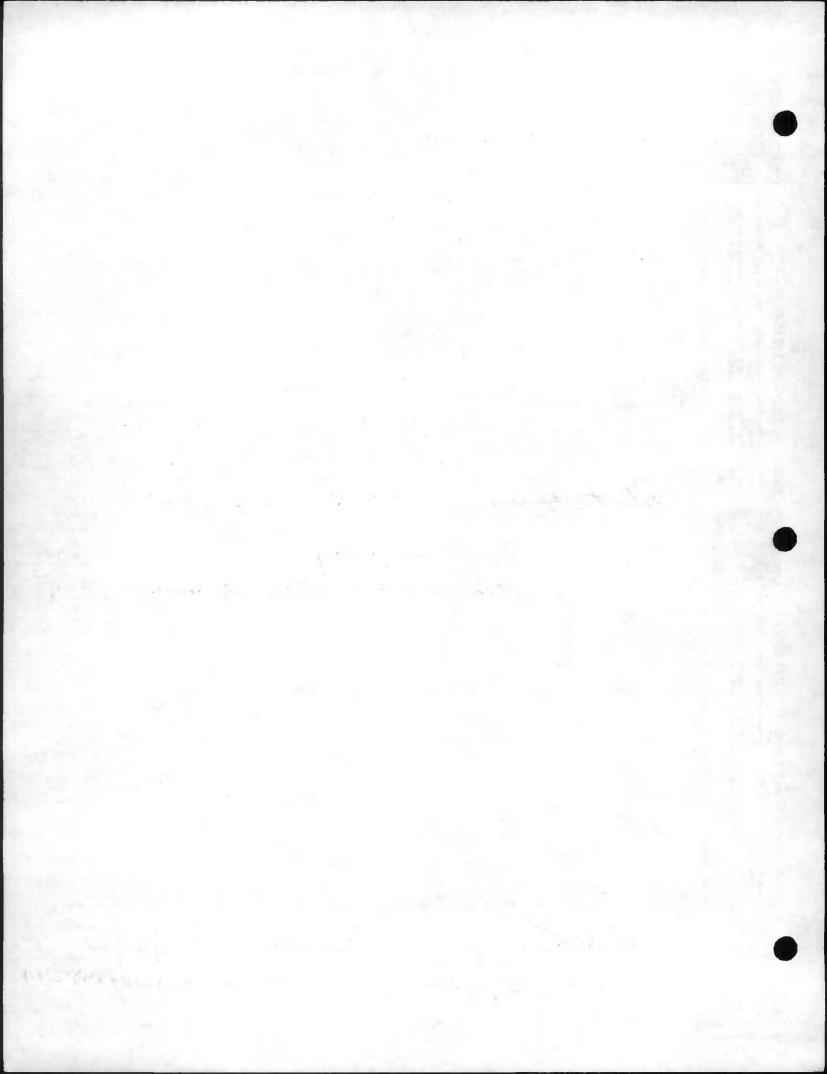
14. Rece - American Indian, Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baitimore, Maryland 21215-0020 p 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wh Department of Health and Mental Hyglens Important: if item 27 is marked other the eny injury or other treumatic avent, that pons. NURSING ASSISTANT 12 **GENESIS** 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) e ALFRED A. WILLEY CONSTANCE M. LIVINGSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED A. WILLEY - FATHER 33014 MT. HERMAN RD. PARSONSBURG, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel from State FOREST GROVE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 1/31/00 PARSONSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final wdjomyons disease or condition resulting in death) Examiner Examiner Resmiratory Distress physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Pert If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 NM6 3 Probably 4 Unknown bengis be det Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? page 2 : 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 5 Pending investigation or Attending death. 1 | Yes 2 | No Liberta after death. 2 Accident 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tilto of contine 29c. License number 29d. Dala signed (Month, Day, Year) D36783 00 s of person who completed cause of death (Item 23a) (Type, Print) 5 SAUSDUNY MD 21801 PRMC Etherfon eu 31. Date filed (Month, Day, Year) JAN 3 1 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Day Month Year **Physician** Janyany 22, 2000 LILLIE S. WILSON 0330 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 20 F Months Hours 216-38-7863 60 5/8/1939 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location fems 23s or 28s-f show 10d. Inside City Limits 1X Yea 2 No Director Wicomico Md. Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 Delaware Ave 21801 Funeral America 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status The Medical Examiner Pages 1 and 2 should be filed within 72 hours after anert of Health and Mental Hygions. ant: if frem 27 Is merked other than "natural", or fre ury or other traumate avent, the Marian Issuria. 1 Never Married Married 21215-0020 1 Yes 2 XNo Specify: Specify: Black by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Laundry Mat Manager Maryland 17. Father's Nama (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Cornish Cecie Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin P. Wilson, Husband 23845 Head of Creek Rd., Quantico, Md 21856

20a. Method of Disposition | Date | 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department of Important: If any injury or page. 4 Donation 5 Othar (Specify) Quantico, Md. Head of Creek Cem. 1/29 21. Signature of Funeral Service Licensee MOO-417 22. Name end Address of Fecility
Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediata Causa (Final · ARTORIOSCIONOTIC GARDI OVASCU LAZ disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ANonia ician end burial-transit CHRONIC that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760. ANGROWE Physician/Medicai Due to (or as a consequence of): Sign USB I Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? o. 1 Yaa 2 No 3 Probably 4 Unknown م Mouries 313-2416 Records. ð 8 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy performed? Completed page 2 s 20 No 1□ Yes 2□ No Division of VItal or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely lilled in by the It 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 12 Certifying Physician To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner as stated.

2 Modicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only onel 29b. Signature and fills of seri 29c. License number 29d. Date signed (Month, Day, Year) D0051743 OD 30. Nama and address of purson who completed cause of death (Item 23a) (Type, Print) Uh 145 E CARPOIL ST SECHLER DAVIA m.0.

DHMH 16 Ray 6/95

State

Registrar

31. Date filed (Month, Day, Year)

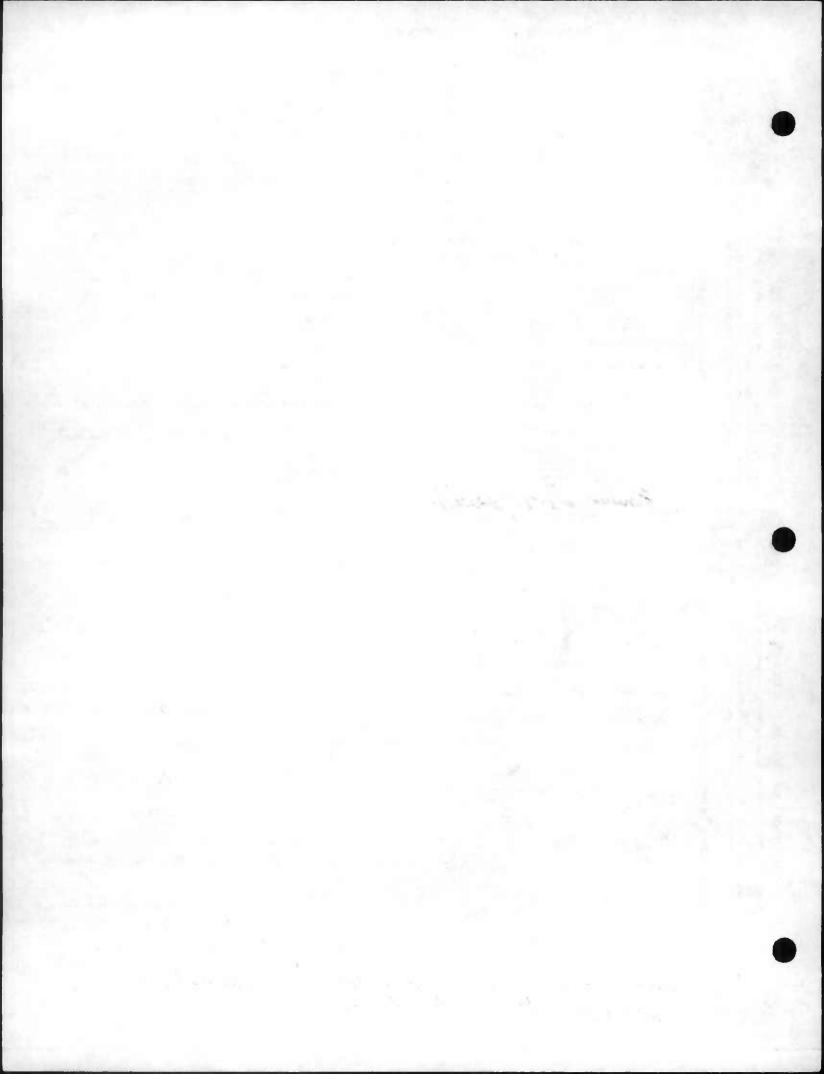
JAN 2 8 2000

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32. Registrar's Signature



If Under 1 Year

10f. Zio Code

Months

Days

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month McPHERSON WHITE 1330

Physician
/Medical
Examiner

4e Facility Name (If not institution, give street end number)

7. Age (In yrs. last birthday)

JAN

3. Time of Death

PENINSULA REGIONAL MEDICAL CENTER

6. Sex 1 M 2 □ F

4b. City, Town, or Location of Death SALISBURY

2000 4c. County of Death

WICOMICO

**Funeral** 

215-12-6375 Usual Residence of Decedent 10b. County

75 10c. City, Town or Location

8. Date of Birth (Month, Dey, Year) If Under 24 Hrs. Hours 5,1924 AUGUST

 Birthplace (State or Foreign Country) MARYLAND

Director

28a-f ahow

6

Nerne 23a

"natural", or

la marked other than

Important: If Item 27 I

Department of

iner must be notified at

Director

Funeral

p

Completed

Be

2

Physician/Medical Examiner

py

Completed

Be

Certification: To

Medical

use as the

Sign

peen page 2

certificate

this

After

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

with the Maryland

Peges 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene.

- /ス-6375 Maryland 21215-0020

1

altimore,

10a. Stete SOUTH CAROLINA BEAUFORT

HILTON HEAD ISLAND

10d Inside City Limits Yos 2□No

10e. Street and Number 20 WILD LAUREL LANE

CHARLES

29926 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A.

10g. Citizen of What Country?

Specify:

11. Merital Status

12

1 Never Married 2 Married 3 ₩ Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Dates: NAVY

1 ☐ Yes 2 No Specify:

14. Race - American Indian, Bleck, White, etc.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

WHITE

17. Father's Name (First, Middle, Last)

ARTHUR PERCY WHITE MARKETING EXECUTIVE 18. Mother's Neme (First, Middle, Meiden Sumame)

JULIA

ADVERTISING COMPANY

19e. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

D.

MARGARET W. PLUM - SISTER

172 BEACON ST. 20b. Place of Disposition (Name of cemetery, cremetory or other place) BOSTON, MA 02116 Date 20c. Location - City or Town, State

20a. Method of Disposition

1 ₺ Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

PARSONS CEMETERY

SALISBURY, MARYLAND 1/28/00

McPHERSON

21 Signature of Funeral Service Licensee

22. Name and Address of Facility CFJO BOUNDS FUNERAL HOME, INC.

705 E. MAIN ST. SALISBURY, MD 21804

**Physician** /Medical Examiner

The lew requires that the death certificate be axecuted

Box 68760.

P.O.

Records,

of Vital

Division

Attending Physician:

Immediate Cause (Final disease or condition resulting in deeth)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death 6 mo 5

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due	to	(or	es a	consequence	of):

28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

Due to (or as a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? Yes 20 No 3 Probably 4 Unknown

24b. Were autopsy findings evaileble prior to completion of cause of deeth?

24a. Was an autopsy performed?

1 Yes 2 No

1 ☐ Yes 2 2 No

Was case examiner? 25. Was case referred to medical

Hospital: 154 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

27. Menner of Death

Mintural

2 Accident

4 T Homicide

31 I Sulcide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. tion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s)

29b Signature and title of part

29c. License number

1 Yes 2 No

29d. Dete signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 145

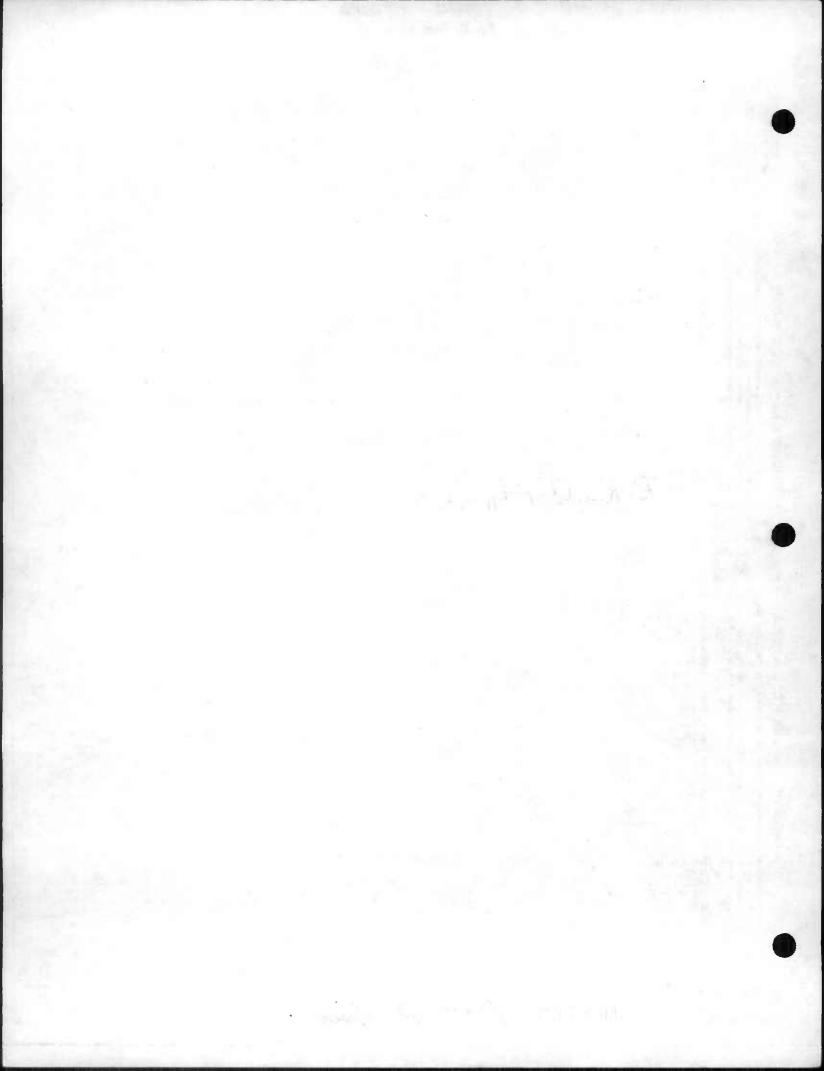
5 Pending

6 Could not be determined

E 32. Registrar's Signature

State

31. Date filed (Month, Dey, Year) JAN 27 2000 Registrar

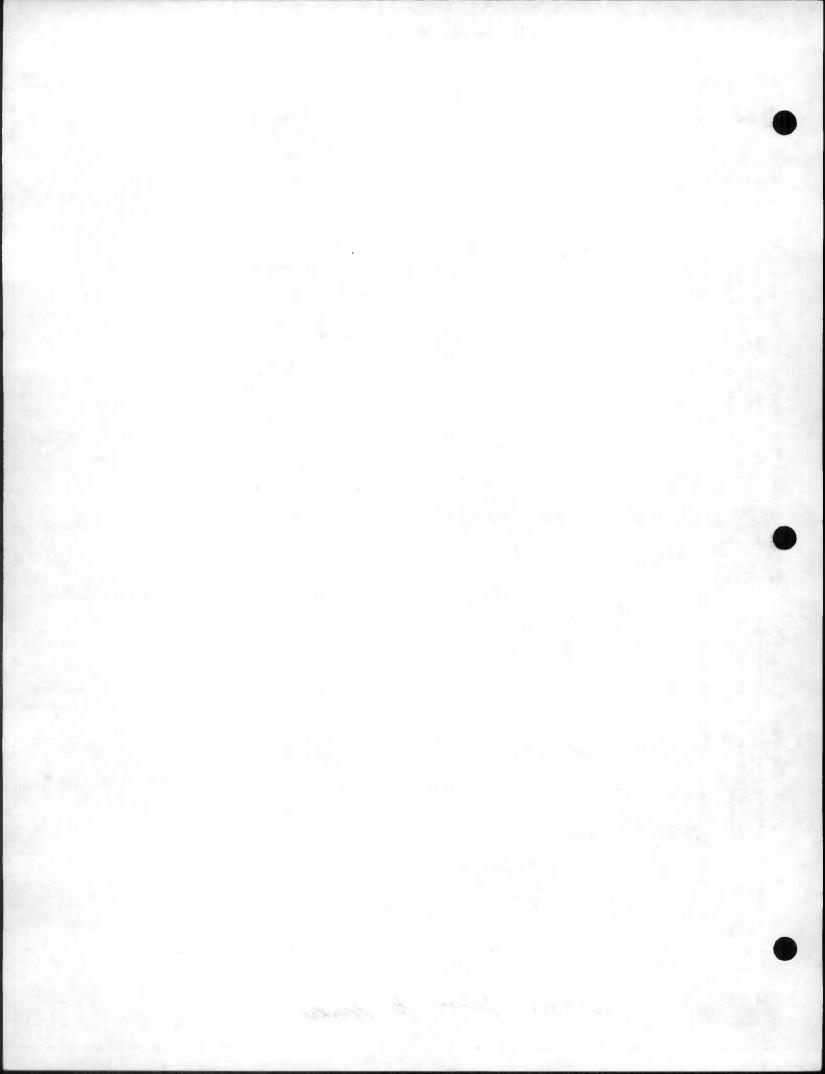


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Viola Darden Wallace January 20, 2000 9: 50 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare MD Wicomico If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 M 2 3 F Yrs. 220-03-5484 **Director** 96 April 19,1903 NC Usuel Residence of Decedent r 28a-f show notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD Wicomico Director Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 238 701 N. Westover Drive 21801 Funeral U.S. 12. Wes Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Merried 2 Married 1 ☐ Yes 2 XNo If Yes, Give 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 € Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Laborer Food 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be for tment of Health and Mental H tant: If flem 27 is marked off Be Rufus Darden Zenobia Holloman 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridgit Reynolds/granddaughter 626 Priscilla St., Salisbury, MD 21801 20b. Place of Disposition (Neme of cematery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Springhill Memory Gardens 1/29/00 Salisbury, MD 21. Signature of Funtial Service Opense 22. Neme end Address of Fecility Lewis N. Watson Funeral Home 23e. Part Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, effects, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final monon sug disease or condition resulting in death) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pug Due to (or es e consequence of): Box 68760, physician Physician/Medical the th Dua to (or es a consequence of): 60 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown م Records, ρ ATRISL ZISTURITION Be Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate Division of Vitai or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicida 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) ca 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

M 1 477 104 Clastific conse Esles mo

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Dey, Year) JAN 2 7 2000



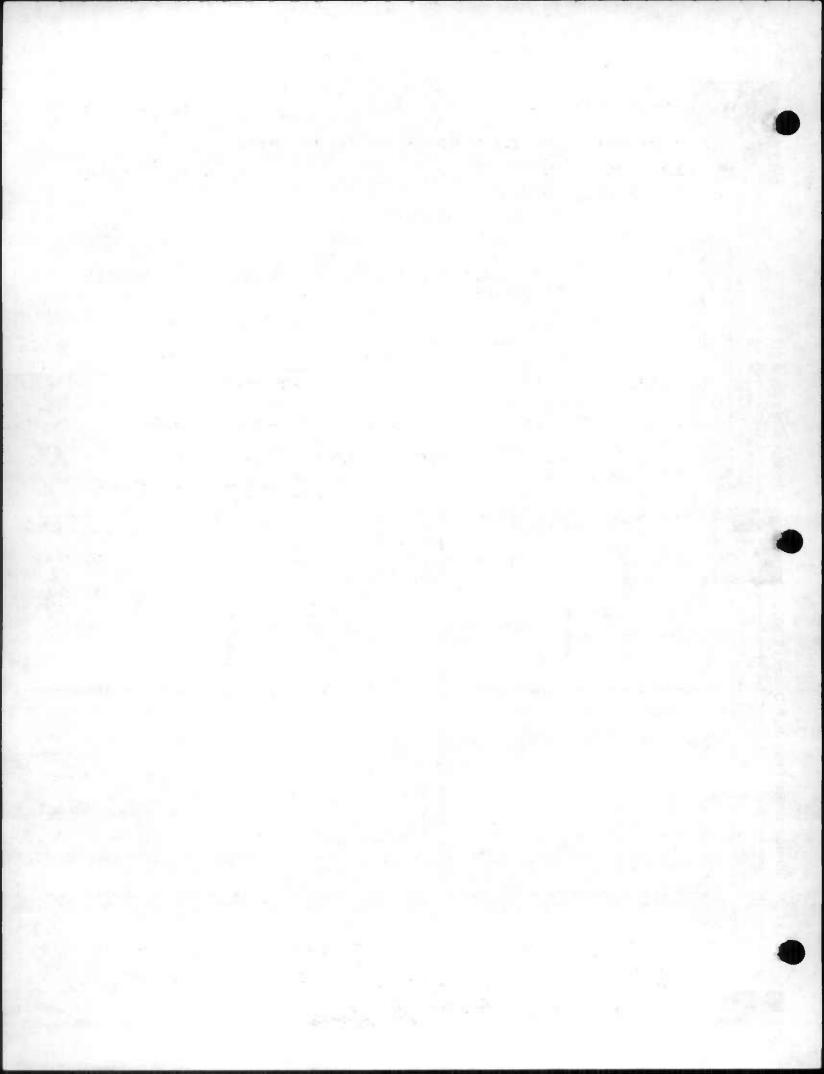
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month FRED WORKMAN 2100 15 7000 /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner UNIVERSITY OF MARTLAND MEDICAL SYSTEM BALTIMORE If Undar 1 Yaar If Under 24 Hrs. 6. Date of Birth (Month, Day, Yaar) 5. Sociel Security Numbar 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1 M 2□ F 221-26-7913 56 Vrs Director DEC. 9,1943 DELAWARE Usual Rasidanca of Dacadant the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show ms 23a or 28a-1 short must be notified a SUSSEX LINCOLN 1 Yas 2 No Director 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of Whet Country? R.D. #2, BOX 248 19960 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Dacedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indien, Black, Whita, atc. 11. Maritel Status traumatic event, the Wedical Examiner Pages 1 end 2 should be filed within 72 hours efter cleen of Heelth and Mentel Hygiena.
Int: If item 27 is marked other than "natural", or item Into yor other traumatic event, me Wester Itematic event, me Wester Itematic 1 Navar Marriad 2 Married 21215-0020 SpecWHITE 1 Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) MECHANIC AUTOMOTIVE Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) PRESTON L. WORKMAN HAZEL MAGEE 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) SHARON WORKMAN - WIFE R.D.# 2, BOX 248, LINCOLN, DE 19960 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stata Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) 1-18-00 DOVER, DE CAPITOL CREMATORY 22. Nama and Addrass of Fecility BERRY-SHORT FUNERAL HOME 21. Signature of Funëral Service Licenses MILFORD, DE 19963 119 NW FRONT ST., 20 se hors 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Physician Immediata Cause (Final disaasa or condition resulting in daeth) /Medical HYPOXIA 12 HOURS Examiner Due to (or as a consequence of): SEIZURE 36 HOURS or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequantially list conditions, if eny, laading to Immadiata cause. Entar Undarlying Causa (Disease or Injury that Initiated evants rasulting in death) Last Due to (or es a consequence of): and Division of Vital Records, P.O. Box 68760. ettending physician END STAGE SYEARS Physician/Medical LIVER DISEASE Dua to (or es a consequence of): signed by the et Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? After this certificate 1 Yas 2 Ne 1 Yas 2 No Be 25. Wes casa referred to madical 26. Pleca of Death (Check only ona) Hospital: 1 Yes 2 No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 2□ ER/Outpatient 3□ DOA funeral 28e. Data of Injury (Month, Day Year) 27. Manner of Daath Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Panding death. 1 ☐ Yas 2 ☐ No 2 Accident Invastigation after death in by the 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the ceusa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data end place, end due to the causa(s) and mennar stated. edicai 29a. Cartifiar (Check only one) 29b. Signetura and titla of certiflar 29c. Licansa number 29d. Data signed (Month, Day, Year) , MD 30. Name and amorass of person who complated causa of deeth (Itam 23a) (Type, Print) Jouth browne Strant Bulliain, MD 21201 4 JULIA SMIN ZOUYOUNG 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) State

**DHMH 16 Rev 6/95** 

Registrar

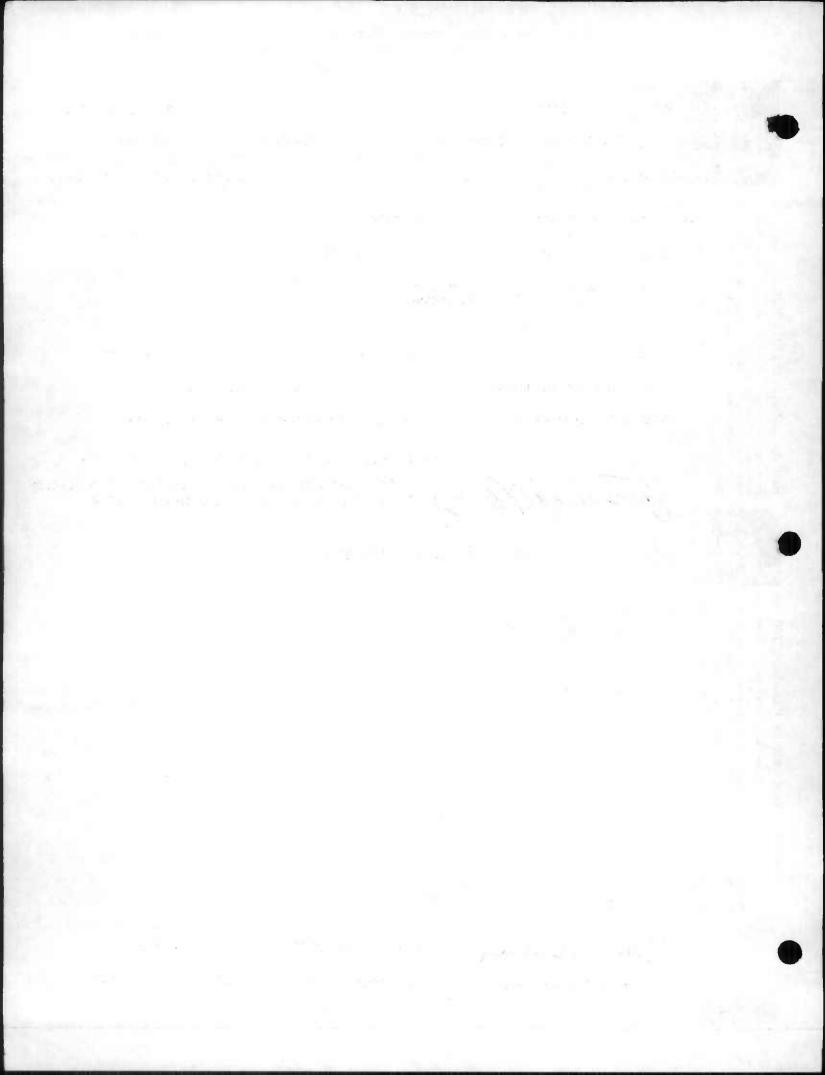
JAN 2 4 2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Depertment of Heelth and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show and important: If Item 27 is marked other than "natural", or items 23s or 28s-f show and in portant in the marked other than any injury or other traumetic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	4a. Facility Name (If not institution PENTINSULA REG 5. Social Security Numbar 203-36-7247 Usual Residenca of Decedent 10a. State 10b. County Maryland Wicc 10e. Street and Number 30075 Southar 11. Marital Status 1 □ Never Married 2 Marria 3 □ Widowed 4 □ Divorcad	ILIAMS  n, giva street end number,  IONAL MEDIC:  8. Sex  7. A  M 2 F  The street of number,  7. A  The street of number,  8. Sex  12. Was Decedant  Amed Forces'  13. Yas 2    14. Yas, Give  Yaar or Dates:	AL CENT! ge (in yrs. last b 53  10c. City, To Sal	yrs. If Und Month wn or Location isbury	ler 1 Yaar	4b. City, Town, or SALISBUR If Under 24 Hrs Hours Min.	8. Date of Bi	Day 20 th 4c. County WICON	Year 2000 001 of Death	
Depertment of Heelth and Mental Hygiene  Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show on any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, in the Medical Examinet must be notified at any injury or other traumetic event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event, and injury or other event,	4a. Facility Name (If not institution PENTNSULA REG 5. Social Security Number 203–36–7247 Usual Residence of Decedent 10a. State 10b. County Maryland Wicc 10e. Street and Number 30075 Southar 11. Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Marri	m, give street end number, 7. A. 12. Mas Decedent Amed Forces 1. Give street end number, give st	AL CENT! ge (in yrs. last b 53  10c. City, To Sal	yrs. If Und Month wn or Location isbury	ler 1 Yaar s Days	SALISBUT	O1 Location of Deat RY  8. Date of Bi (Month, De	20 th 4c. County WICON rth ey, Year)	2000 001 y of Death MICO 9. Birthplaca (Steta Country)	
Depertment of Heelth and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show on any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event, the Medical Examinet must be notified at any injury or other traumetic event.	PENINSULA REG  5. Social Security Numbar  203-36-7247  Usual Residence of Decedent  10a. State 10b. County  Maryland Wicc  10e. Street and Number  30075 Southar  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad  15. Deceden (Specify only higher  Elementery/Secondary (0-12) 12	8. Sex 1 M 2 F  Omico  mpton Rd.  12. Was Decedent Amed Forces 1 Gyas 2 H 78s, Give Yaar or Dates:	AL CENT! ge (in yrs. last b 53  10c. City, To Sal	yrs. If Und Month wn or Location isbury	ler 1 Yaar s Days	SALISBUT	8. Date of Bi	WICON	MICO  9. Birthplaca (Steta Country)	ı or Foreian
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Department of Heelth and Mental Himportant if New 27 is marked out and inportant. If New 27 is marked out any injury or other traumetic even once.		College (1-4or	5+)	life. DO NOT	use retire	during most of wo	Kiiig			
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ysician Medical aminer	19a. Informant's Neme/Relations Carlene Willia		19			end Number or Ri nampton R			Stete, Zip Code) MD 21804	
nysician Medical caminer	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemet	of Disposition (A e <i>ry, cre</i> metory o bia Garde	r other ple		Date 1/25/00		City or Town, State	
Medical caminer	21. Signature of Eurera Service	Licensey D.	ran			Funeral Hill Rd.			al Associa	ation
physician and s the burial-transit	Immediate Cause (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	a. ACUTE M	Due to (or as a	AL INFAI	f):	N				
for use a	that initiated events resulting in death) Last	d		in the underlying		ven in Part I.			entribute to the cause	
signed by deta							1	Yes 2□No	3 □ Probably 4 □	X Unknown
s been 2 shoul	4-4-							s an autopsy ormed?	24b. Were autopsy available prior complation of of death?	r to
pege Com							10	Yes 2 No	1 ☐ Yes 2	□ No
certificate rector, pag	25. Was case referred to medica	1				26. Plece of De	eth (Check only			
0 D	examiner? 1 <del>M</del> Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ant 2/1/ER/C	Outpatient 3	DOA Oth	hor:		ldenca 6 □Oth	ner (Specify)	
octor: After this by the funeral iffication: T	27. Menner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of Injury	ury 28b.	Time of Injury	28c. Inju		1	how injury occur		
is effer death.  In Director: Affert ed in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could a determined	ined 200. Place of in	jury - At home, tc. (Specify)	ory, office		28f. Location City or To	(Street end Numb own, Stete)	ber or Rurel Route Nu	im <i>ber</i> ,	
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	29a. Certifler 1☐ Certifyin (Check only one) 1☐ Certifyin	g Physician: To the best Examiner: On the basis of and manner st	of examinetion e	ge, death occurre ind/or investigation	ed at the til	me, date and place ppinlon, deeth occi	, and due to the irred at the time	cause(s) and ma date end plece,	anner as stated. and due to the cause	)(s)
To the company	29b. Signatura and title of certifie	r		2	9c. Licens	se number		29d. Date signe	ed (Month, Day, Year)	
	A. Land	3 4 6 ba Da.								
-IVA	Mr. al			DME	D000	3599		1-20-2	2000	
State	30. Name and address of person JOHN T. BULKI		death (Item 23a	) (Type, Print)		3599 STREET	SALTS	1-20-2 BURY, MD		

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month sie February 07, 2000 12', 40 Am ocation of Deeth 4c. County of Deeth Mae Wongus 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth Bay Mallard Center Cambridge vrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8-bate Care Dorchester 5. Social Security Number 8: Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 10 M 20F Deys Hours 90 Yrs. 215-16-8715 February A, 1909 Mary land Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 THYES 2 No MID Dorchester ambridge 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 520 Avenue USA 21613 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merrled 1 Yes 2 LN6 Specify: Specify: Black 3 DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Seafood Line -Helper Seafood Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Josephine Chester Thomas Stewart 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3538 Aeberle Road East New Market, MD 21631 Dete 20c. Location - City or Town, State Barbara Wongus-Woolford 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1 Burial 2 Cremetion 3 Removel from Stete 2/12/2000 Cambridge, Maryland Cordtown Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Henry Funeral Home, P.A. 21. Signeture of Funerel Service Licansee 23e. Pert1 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximete Intervel Between Onset end Deeth Immediate Cause (Final 6 mas diseese or condition resulting In death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other:

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Division of Vital or Attending Physician:

After

within 24 hours after der To the Funeral Director completely filled in by th

To the

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

Be

**Funeral** 

Director

8 Berns 23a

'natural', or Item dical Examiner

In and Mental Hygians.

7 is marked other than "natur fraumatic event, the Medical.

permit. Pages 1 and 2 s Department of Health an Importants If Nem 27 is any Injury or other trau once.

filed within

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

Examiner in 24 hours after death.
the Funeral Director: Aft

Physician/Medical Completed by Be P Certification:

edicai

29a. Certifier

ate hes been signed by the atte page 2 should be deteched for director.

25. Wes case referred to medical examiner? 1 Yes 3€ No

27. Menner of Deeth 5 Pending

1 ☐ NaturaT 2 ☐ Accident Investigation 6 Could not be determined 3 ☐ Sulcide 4 Homicide

(Check only one)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Eurlack MD 21643

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

iddress of person who completed cause of deeth (Item 23e) (Type, Print) en # 302 e

31. Dete filed (Month, Dey, Yeer)

29b. Signeture end title of certifier

FEB 14 2000

32. Registrer's Signeture

State Registrar

Market And of the Authority

State of Maryland / Department of Health and Mental Hygiene

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	Physician /Medical		ecedent's Nam CLAUI	DE MARVI		BURN						JANUAR		,200	O Ö <sup>ear</sup>	3. Time of Deeth 04:50 AM
	Examiner	4a I		If not institution, given the leart Hosp		um <i>ber)</i>				4b. City, To		ocation of Dea		Alle	of Death	
	Funeral Director	2:	ociel Security N	413	Sex 10X M 2□ F	7. Age (In ) 67	rrs. last birthda Yrs.	Mont	hs Deys		24 Hrs. Min.	8. Date of Bi (Month, D July 1	rth ey, Year 19	32	9. Birthpli Count Mary	aca (State or Foreign land
	Maryland of ahow	10a.	al Residence o State	10b. County Garret	t	10c.	City, Town or Grant		le						10	od. Inside City Limits
	uffer death with the Manyland in thems 23a or 28a-f show effer must be notified at Funeral Director	10e. 6	Street end Nu 94 Blac	mber kberry La	ane			10f.	Zip Code	215	536		10g. Ci	itizen of V	What Count	ry?
020	5 2 3 3	11.	Meritel Status  Never Marr  Widowed	ied 2⊠ Merried 4 □ Divorced	Armed F	2 No	n U,S. 1		s 2K No			pecify Yes or N Rican, etc.)	0-		ce - America ck, White, e v: White	ife.
Maryland 21215-0020		E	(Speciementery/Second 7 th	15. Decedent's E city only highest gro ondary (0-12)	ade completed,	) (1-4or 5+)	(Gi	ve kind of DO NO	Jsuel Occu work done Tuse retire	during mos	st of wor	king	Gar			ty Roads
yland	Mental Hy arked other aric event	17. F	alter W	(First, Middle, Last lilburn	)							e (First, Middle a Wilt				
, Mar	pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiena. Important: if item 27 is marked other than any holiury or other traumatic event, the Nables.  To Be Compl	19a G	oldie C	eme/Relationship			694	Blac	ckber	ry Lar		ral Route Numl Grantsv	ille	, ME	215	36
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ital F	certificate he rector, page	25. \		red to medical						26. Place	e of Dee	th (Check only		№ No	1□	Yes 2□ No
	his his		Agner of Deat  Natural  Accident	h 5 Panding investigatio	28a. Dete (Mor		ER/Outpat 28b. Time (njur	of	28c. Inju			ome 5 ☐ Res 28d. Describe				)
Division	xetc L		3 ☐ Suicide 4 ☐ Homicida	8 Could not be determined	286. Place	e of Injury - A ling, etc. (Spe	t home, ferm, ecify)	sfreet, fac	ctory, office			28f. Location City or To	(Street e own, Stet	nd Numi	ber or Rural	Route Number,
	To the Hospital c within 24 hours at To the Funeral D complately filled i	290.	Certifier (Check only one)	1⊠'Certifying Ph 2☐ Medical Exar	niner: On the b	e best of my le pasis of exam oner steted.	nowledge, de inetion and/or	ath occur investigat	red at the t tion, in my	ima, date ar opinion, des	oth occur	and due to the red at the time	ceuse(s , dete an	s) and mo id placa,	enner es sti and dua to	ated. the cause(s)
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	mes	30. N		ess of person who ERT WELIK			tem 23a) (Typ		RLAND	,MD.	215	02			C	,
	State	31. [	FEB 0			Registrar's Sk	-	loa.	h							

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State of Maryland / Department of Health and Mental Hygiene 00 0637

			Centica	ate of Death		Reg. No.	
Physician	Decedent's Nama (First, Middle, Last)		1.01	LL15	2. Data of Dea	Day	Year 3. Time of Des
/Medical	MALLIE		w 1		Febraya		
Examiner	4a Facility Nama (# not institution, give s	CONTRACTOR OF THE PARTY OF THE			r Location of Death		of Death
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Funeral		M 2 F 7. Age (In yrs.	Yrs. Month		n. (Month, Da)		9. Birthplaca (State or Fo
Director	Usual Residence of Decedent	18			02-04	+-221	MRGMIT
ms 23s or 28s-f show rmust be notified at neral Director	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Li
to to	DFL.	FY	GALLFUR	d			1 □ Yas 2 2
r 284	10e. Street and Number			Zip Code		10g. Citizen of Wi	hat Country?
r Nems 23s or 28s-1 s niner must be notified Funeral Director	Route 1, Box	x 62-A		19145	1	In ted	States
ner me		12. Was Decedent Evar in U. Armed Forcas?	,S. 13. Was Dec	cedent of Hispanic Origin? ( becify Cuban, Maxican, Pue	Specify Yas or No-	14. Raca	- American Indian, Whita, atc.
F 5	1 Nevar Married 2 Married	1 XYes 2 No		2 No Specify:	into rican, etc.;		, whita, atc.
tal tygiene. d other than "natural", or tems 23a or 28a-f show event, the Madical Examine mass be notified at event, the Madical Examine mass be notified at Be Completed by Funeral Director	3 Widowed 4 □ Divorced	Year or Dates: WI	L	212140 Specify.		Specify:	BIGCK
ygiene. Werthan "neturn n, tre Wedell Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us	sual Occupation work done during most of w	orkina	16b. Kind of Bus	siness/Industry
mple mple	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		11.	
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Wental Hygiene. rked other than ritic event, the Man	17. Fathar's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden Sumame	
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f Health and Mer them 27 is merke other treumetic	19e. Informant's Name/Relationship (Typ.	oe, Print)		ss (Street and Number or I	Rural Route Numbe	City or Town, S	State, Zip Code)
of Health from 27 r other tr	Louise DIXON	laot s		mercury	PL. Ph:	ladel Phi	4 19.1915
	20a. Method of Disposition  1. Burial 2 Cremation 3 Re		Pleca of Disposition (A cemetery, crematory o	r other place)	Date		City or Town, State
	4 □ Donation 5 □ Other (Specify)	H	dly TR.	nity	2/12/00	Painter	-, Va
Department of Important: If any injury or phice.	21. Signature of Funeral Servica Licanse	lê .	22. Name	and Address of Facility	Noral H	one	1
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nysician		0 0000 0 0001, 11					Onset and Deat
Medical	Immediate Cause (Final disease or condition	Seasis					Ohe wee
kaminer	resulting In death)	Jepsis Due to lo	or as a consequenca o	n):			one wee
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or us			Line Line				
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een signed rould be del	Emphysema				24a. Was	an autopsy rmed?	24b. Were autopsy findia available prior to
as been signed by the attending p 2.2 should be detached for usa as a pleased by Physician/Me	Emphysema				24a. Was	an autopsy rmed?	24b. Were autopsy finding available prior to completion of caus of deeth?
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nis certificate has a director, page 2	25. Was case referred to medical exeminer?  1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending invastigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifler (Check only 2 Medical Examin	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifician: To the best of my knower: On the basis of examine)	28b. Time of Injury M ome, term, street, fact y) wledge, deeth occurre tion and/or Investigeti	DOA Other: 4 Nursing  28c. Injury at Work? 1 Yes 2 No  ory, office  ad et the time, date end ple on, in my opinion, deeth occurrence.	eath (Check only of the state o	rmed?  (es 2 No  ne)  tenca 6 □Othe now injury occurre  Street and Number  on, Stata)	available prior to completion of caus of deeth?  1  Yes 2 No  r (Specify)  and  or or Rural Route Number,  nner es stated,  nd due to the cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Physician FEBRUARY 8, 2000 03:00 A.M. WILLIAMS /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 12M 2DF Vrs 214-36-6464 Director Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Examiner must be notified Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **5 Mount Pleasant Street** 21532-Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No H Yes, Give Yes, Control of the Control 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) housekeeping department 12 state university 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 should be II h and Mental H is marked off 89 permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked c any Injury or other traument 2 Harry Williams Elizabeth Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean M. Williams Maryland 21532sister 5 Mount Pleasant Street Frostburg 20a. Method of Disposition

1 Buriel 2 Cremation 3 Removel from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State Frostburg Memorial Park 4 Donation 5 Other (Specify) 10-Feb-00 Frostburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final dan disease or condition resulting in death) Examiner 11 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue ute Myo Cardia
Due to (or as a consequence of): Box 68760 11 Physician/Medical the two mubrish 11 11 er char P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown á 1 Yes 2 No Di Scase signed a Records, p 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy terten 8200 certificate ! 200 NO 1 Yes 1 Yes 2 No Division of Vital iai or Attending Physicien: The ster death.

Si Director: After this certificated in by the funeral director, ps 25. Was case referred to medical Be 26. Placa of Death (Check only ona) examiner? 1 Danpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 200 No 1 Yes Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleida To the Hoepital or within 24 hours eft To the Funeral Di completely filled In Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) My FEBRUARY 8 , 2000 D14464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

State Registrar

ViKander 31. Data filed (Month, Dey, Year)

FEB 1 0 2000

DHMH 16 Rev 6/95

Grace trostoura MD

M.D.

32. Registrar's Signature

Vertexpeed A	DELEGI	Circin		fort Cyc	Sacred Harmin
g-3 <sup>o</sup> Maryland	A-05.		CA		5010-18 B1
			pivdteori	llegany	Maryland A
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Ain (VV					
december sents		osekeeping departm	ort	O	12
	oeth Evans	Elizat			Horry Williams
Mayland 215%-	frostburg	Wount Pleasant Street	3	retais	Jean M. Williams
O Frostburg Maryland	10-feb-0	Memoral Fort	O1U 112011		

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

#### Please '

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Du not enter the mode of dying, such as cardiac or respiratory arrest,

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Philos Cemetery

RESPIRATORY FAILURE

ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Due to (or es a consequence of):

Due to (or as a consequence of):

CONGESTIVE HEART FAILURE

CHRONIC OBSTRUCTIVE LUNG DISEASE

	Plaa	se Type or	Print In Blac	k In	dallbla	Ink	Acei	ıro A	II Conles	Arelec	ılhla		
	T ICU		of Maryland / I	<b>Depa</b>	artment	of H	lealth a	and N				063	73
				Cei	rtificate	of .	Death			Reg. No.			
	me (First, Middle								2. Date of Dec Month	ath Day	Year	3. Time of I	Death
Naomi	Mae Walk	er							JANUAR	Y 29	2000	2100	PM
a Facility Name	(If not institution,	give street and nu	imber)				4b. City, To	wn, or L	ocation of Death		ty of Death		
Sacred	Heart H	ospital					Cum	berl	and	A11	egany		
Social Security 214-74-		6. Sex 1 M 2 F	7. Age (In yrs. last bit	rthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 09/23/	v. Year)	9. Birth	place (State or ntry) WV	Foreign
sual Residence	of Decedent												
0a. Stata	10b. County		10c. City, Tow	n or Lo	cation	- 11-					1	Od. Inside City	Limits
MD	Alleg	any	West	ernp	port							1 Yes	2 🗆 No
De. Street and N	umber				10f. Zip (	Code				10g. Citizen o	What Cou	ntry?	
25701 S	hady Lan	e SW			2	156	2			USA	-10		
	rried 2 Marrie	Armed F	2 No		Vas Decede f Yes, specil l □ Yes 2		lispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. Ri			

288-1 Berns 23s or munt be permit. Pages 1 and 2 about be filed within 72 hours after a Department of Health and Mertal Hygiens, introportant if Nem 37 is rearked other than "netural, or then any injury or other traumatic event, its Medical E., or then 9068. Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

The law requires that the death certificate be axecuted

certificate has

After this

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

To the

ician and bunal-transit physician s the buna 100 esn signed by the atte plnods page 2 funeral director. Be

Examiner Physician/Medical Completed by Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

23a. Part1. Enter the disease, or complications that caused the ahock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 | Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Elementary/Secondary (0-12)

20a. Method of Disposition

21. Signature of Funeral Se

17. Father's Name (First, Middle, Last)

W. Juluis Brumback

Mildred Moorehead

4 ☐ Donation 5 ☐ Other (Specify)

19e. Informant'a Neme/Reletionship (Type, Print)

5. Social Security Number

10e. Street and Number

11. Marital Status

10a. Stata

Director

Funeral

þ

Completed

Be

Usual Residence of Decedent

15. Decedent's Education (Specify only highest grade completed)

1 ■ Burial 2 □ Cremation 3 □ Removal from State

College (1-4or 5+)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1☐ Yes 2☐ No

29c. License number

D15463

281. Location (Street and Number or Rural Route Number, City or Town, State)

21562

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Placa of Death (Check only one)

10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

**JANUARY 30 2000** 

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

24a. Was an autopsy parformed?

16b. Kind at Business/Industry

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death?

Approximete Interval Between Onset and Death

5 days

5 days

8 years

10 years

3 Probably 4 Unknown

24b. Wera autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Westernport, MD

Own Home

18. Mother's Neme (First, Middle, Maiden Surname)

Maude (Shipe)

213 Kelley Avenue Westernport, MD 21562

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

02/03

Piedmont, WV

Fredlock Funeral Home

30. Name and address of burson who is Sause of death (Item 23a) (Type, Print)

90 MAIN STREET WESTERNPORT MARYLAND SHIN KIM, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

J. ..... See James J.

Division of Vital Records, P.O. Box 68760,  To the Hospital or Attanding Physician: The lew requires that the death cartificate be associted within 24 hours after deeth.  To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bufal-transit and properties and properties of the properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and properties of the physician and ph	Baltimore, Marylan	permit. Pages 1 and 2 should be Department of Health and Mental Important: if frem 27 is marked of any frilury or other traumatic ave price.	To Be
M Santa	-		edical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Beatrice Warner 214-07-6424

								Cer	rtificat	e of	Death		F	Reg. No.	0 1	10	14
			1. Decedent's Nama	(First, Middle, La	st)		26.74				- 111		2. Data of Dea Month	ith Day	Year	3. Tin	na of Death
	Physicia /Medica	_	BEATRI	CE WARNI	ER								Februa		2000	3	:24 a.m
	Examine		4a Facility Nama (If r	not institution, giv	e street and n	umber)					4b. City, To	own, or L	ocation of Death	4c. Count	y of Death		
			Memorial	Hospita	1						Cumb	erla	and	A11	egany		
	Funeral Director		5. Social Security Nur 214 07 642		Sex I□M 2√F	7. Age 82	(In yrs. last b	virthday) Yrs.	If Under Months			24 Hrs. Min.	8. Date of Birth (Month, Day MAY 20	1917	9. Birthy Cour MARY		ate or Foreign
	pu a	- 1	Usuat Residence of E	Decedent 10b. County			10c. City, To	wn or Lo	cation						1	Ind their	de City Limits
	Sa-f sho	ctor	MARYLAND	ALLEGAN	Z		FROST									XIX	Yas 2□No
			10e. Street and Number 226 WELSH						10f. Zip	21.	532			ntry?			
020	5 43	by Fur	11. Marital Status  1 Never Married  3 Wildowed 4		12. Was De Armed F 1  Yas If Yes, G Year or	orces? 2 XNo iva					Hispanic Or pan, Mexical Specify:		ecify Yas or No- Rican, etc.)	14. Ra Bla Specia	ce - Amaric ack, Whita, fy:		
Maryland 21215-0020	within 72 handen. The Medical	Completed		5. Decedent's Education only highest gra	ide completed	) (1-4or 5+		Give	dent's Usu kind of wo DO NOT u	al Occu rk done se retin	pation during mos ed)	st of work	ring	16b. Kind of E	Businass/In	dustry	
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Mar	d 2 sh ith and iff is m it fraum		19a. Informant's Nam JOSEPH RAE										al Route Numbe				
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E	Page net: If ary or	1	1 ☑ Burial 2 ☐ 4 ☐ Donation 5			State						K 2	2/6/00	FROSTBI	URG.	MD	
Baltimore,	mit ports y inju		21. Signature of Fund	eral Service Lieur	1500			22	. Nama ar	nd Addr	ess of Facili	ity					
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er ·	/Medical Examiner		Immediata Causa (Fi disaasa or condition rasuiting in death)	nai	a. Pneu	_									1	3	days
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0	ng Ph		27. Manner of Death	5 Pending	28a. Data (Moi	of injury	Year) 28b	Tima of injury	1	8c. tnju	iry at		28d. Dascribe h	ow injury occu	urred		T-A
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	4	-	30. Nama and addres	s of person who	completed cau	ise of dea	ith (Item 23a	(Type.		D40.	740			Tebrue	J	, = 0	- 0
			Dr. Shak							nue	Suit	e 30	)4, Cumb	erland	, MD	2150	2
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**ORIGINAL** 

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** 17:40 PM MAE WIGFIELD BESSIE 27 00 01 /Medical 4e Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY if Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, JULY 10 5. Sociel Security Number 9. Birthplace (State or Foreign W. VA. 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 10 M art 85 Yrs. 577-09-1053 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo W. VA. MORGAN PAW PAW r than "natural", or hams 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BETHEL ROAD 25434 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Stetus Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes ANNo
If Yes, Give
Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER/OPERATOR BESSIES BEAUTY SALONS HAIR STYLING permit. Pages 1 and 2 ahould be the Department of Health and Metual Hy Important: If hem 27 is marked oths any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDGAR SURFACE 2 HATTIE WICKLINE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY GROSS DAUGHTER HC 86 BOX# 414 FORT ASHBY, W.VA. 26719 20b. Placa of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CAMP HILL CEMETERY JAN 31 2000 PAW PAW W.VA. 22. Neme end Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. 21. Signature of Funeral Service Licen. outo 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) CARDIAC ARREST 45 Min ( ASYSTOLE **Examiner** Due to (or as e consequence of): Examiner 5 YEARS THYPERTENSIVE CARDIOVASUALAR DISEASE burial-transit and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760 edical Due to (or as a consequence of): 89 Physician/M 950 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION, CHRONIC ATRIAL P 24a. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to Completed Deen completion of cause of death? has 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Wes casa referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t completely filled in by the funera Certification: After 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 29a. Cartifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. (Check only 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) M.D D -23334, MARY LAND JANUARY 28th noh (23334) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (6 Ave Ste # 201 Cumberland . MD 21502 Dinesh B. Shah. Kent 625 CIM JAN 3 1 2000 32. Registrar's Signature Registrar

DHMH 16 Rev 6/95

JANES 3000 James & Sporter

Please Type or Print In Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Webb **JANUARY 27, 2000** 1803 4c. County of Death
Allegany 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cumberland Sacred Heart Hospital Hours Min. J. Path. Pat. Year 1930 9. Birtholace (State or Foreign County) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 20 F Months Hours 69 215-26-6625 Yrs. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yas 2 No Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 106 Grand Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 □ Never Merried 2 □ Merried 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed ♣ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) (Bowers) Mary C Gerald Vernon Tichnell 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State Zip 28054 John D. Webb 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park! 1/30/ Cumberland, MD 25 carpets Fruneral Home P.A. 21. Signature of Funeral Bervice Licensed 21502 Cumberland, Maryland lications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. 23a. Pert1. Enter the disease, or complications t shock, or heart feiture. List only one cause Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Due to (or as a cons Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examinar roust be notified at

permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Introcramt: if item 27 is marked other than "natural, or her eny injury or other traumatic event, the Medical Ferresponds.

Baltimore, Maryland 21215-0020

the Maryland

Shirley

10a. State

11. Merital Status

MD

Directo

Funeral

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The law requires that the death certificate be executed

Box 68760.

Division of Vitai Records, P.O.

or Attending

Examiner Physician/Medical p Completed B 2 Certification:

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State Registrar

ettending physician end for use as the burlal-transit signed by the e should b + has certificate this funeral After To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Afte completely filled in by the fune

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 PNeturel

2 Accident 3 Suicide 4 Homicide 29e. Certifier

(Check only one)

5 Pending investigation 6 Could not be determined

Hospital:

1 Dinpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of tnjury (Month, Day Year) 28b. Time of tnjury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

se of death (Item 23a) (Type, Print)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

29c. License number

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Deeth (Check only one)

24a. Wes an eutopsy performed?

1 Yes 2 No

28d. Describe how Injury occurred

29d. Date signed (Month, Dey, Year) JANUARY 28, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed ca Clari

29b. Signature end title of ceptible

Wagoner 31. Dete filed (Month

Bishop 25 Registrar's Signeture 32

Walsh Rd. Cumberland, MD 21502

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

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State of Maryland / Department of Health and Mental Hygiene

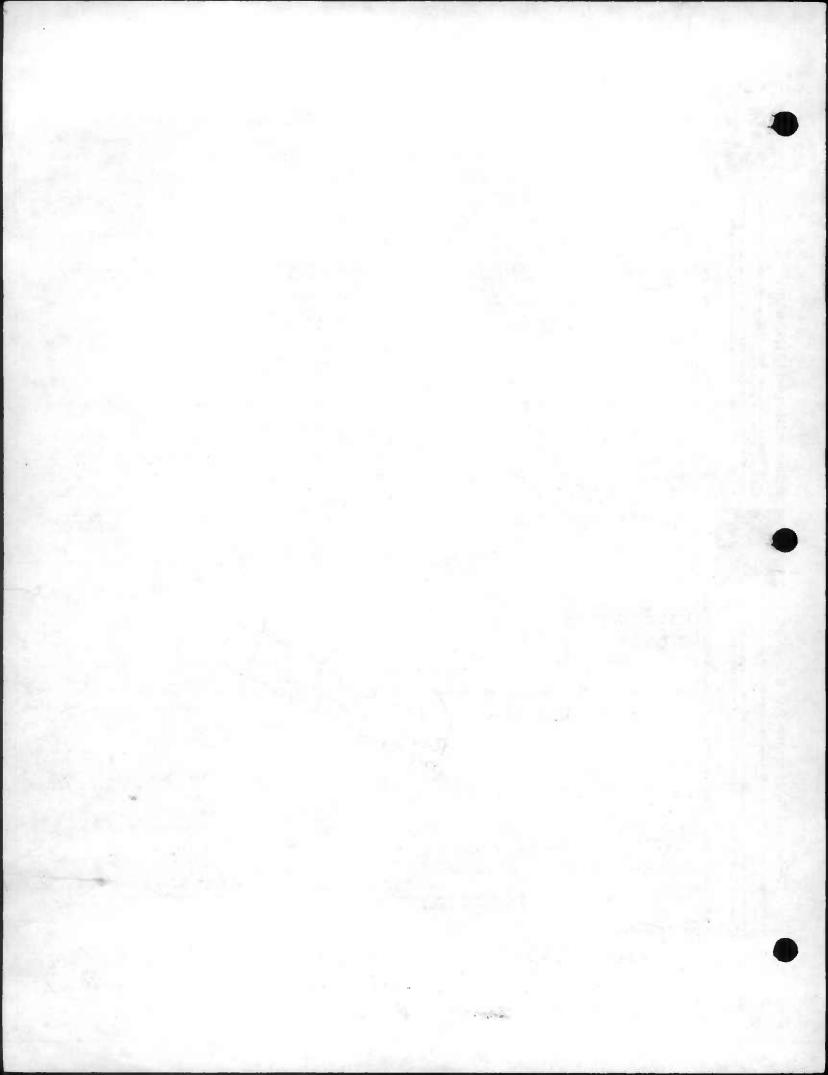
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Hu Eric 0755 2000 Jan /Medical 48 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of mary land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar Months Deys If Undar 24 Hrs. 6 Sex 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** M 2□F Hours Yrs. Director 40 Aug. 8, 1959 212-72-7491 Maryland Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar main to notified at 1 □Was 2 □ No Director Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 USA 11 1st Ave. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 11. Marital Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian Black, White, atc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "nat, eny injury or other traumatic event, the Medical DRGs. Elementery/Secondary (0-12) College (1-4or 5+) Service Technician Bell Atlantic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Young Ellen Avis Albert Dorothy Epling 19e. Informent's Neme/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robin A. Young (Wife) 11 1st Ave., Emmitsburg, MD 21727 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/29/00 Daysville, Maryland Union Chapel Cemetery 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. Thurmont, MD 21788 615 E. Main St., 23a. Part J. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burlat-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 8 280 and a great and a Part II. Other algnificant conditions contributing to death but not real P.O. Do Patri Mactical 23b. Did tobacco use contribute to the cause of death? Reviewed signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 s certificate has 1 Yes 2 3 No 1 ☐ Yas 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2□ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury P M To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funera 28c. tnjury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel Jan 15,200 1 Yas 2 No Fall 2 Accident 3 ☐ Suicide down 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Home First Aule, Emmitsburg, MD 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner stated. edical 29e. Certifier (Check only one) 29b. Sertifure and title of certifit 29c. License number 29d. Date signed (Month, Day, Year) Jan 28, 1242 30. Name and address of person (Item 23a) (Type, Print) TERRENCE LOSTUS 31. Data filed (Month, Day, Year) State FEB: 01 2000 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 05378

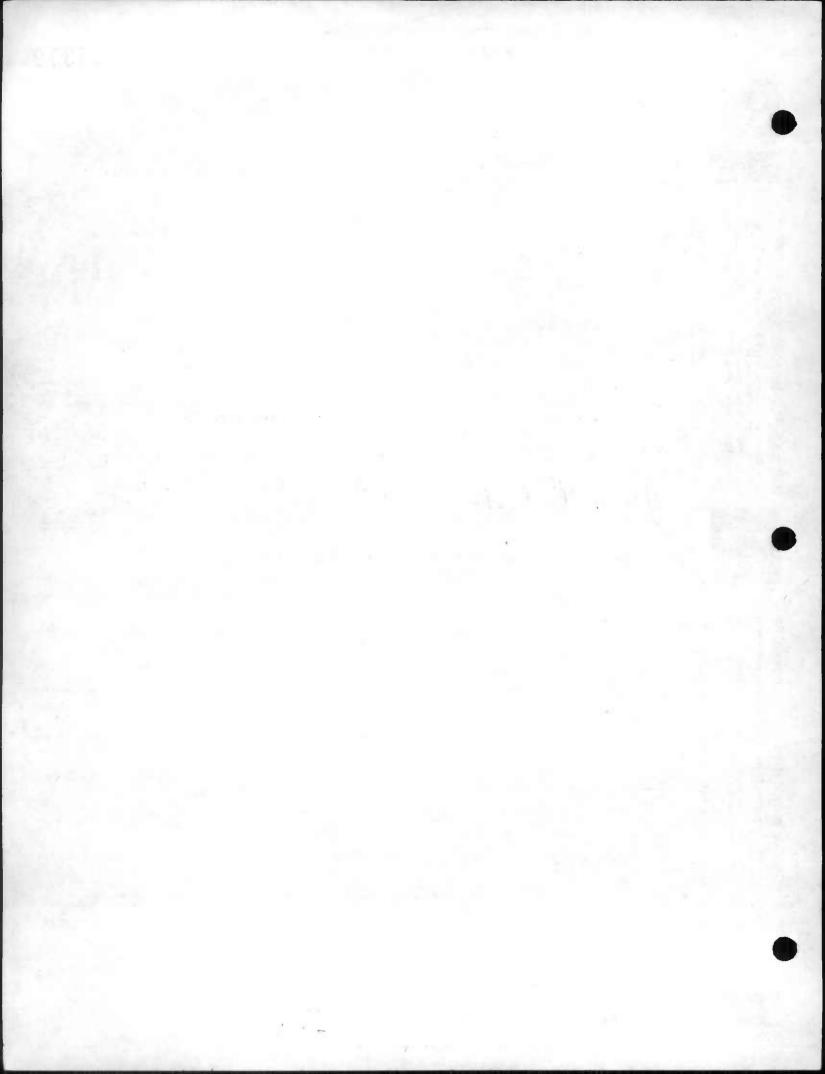
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/Medica	NELLIL			BK	OWI		FEB.		-000	2:04	
Examine	4a Facility Name (If not institution, given Johns Hopkins E	street end number)	edical	Cente			r Location of Deal	,	of Death		
Funeral Director	5. Social Security Number 6. 9 2 37-18-0868 Usual Residence of Decedent	Sex 1□ M 2X F 83	(In yrs. last birth Y		er 1 Year s Days	If Under 24 Hr Hours Min			9. Birthplace (Sta Country) North Car		
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certification in Bank	25. Was case referred to medical examiner?	Hospital:	-5		Ott		eath (Check only				
2 2 2		28a. Dete of Injury (Month, Day	28b. Ti		28c. Injui	4   Nursing	-	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
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To the Hospital or At within 24 hours eiter or To the Funeral Direct completely (illed in by Medical Certiff	29a. Certifier (Check only one) Certifying Pt 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xaminetion end	death occume or investigation	od at the tir	ma, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) and m , data and place,	anner as stated. and due to the cau	se(s)	
To To To To To To To To To To To To To T	29b. Signature and little of certifier  Wen-Hsi any Lee, M.D.  29c. License number  29d. Date signed (Month, Day  P20308 (Bay view #).  Feb. 24, 200										
0	30. Name and address of person who				2030	8 (Bayv	iew #).	teb. 21	4,2000		
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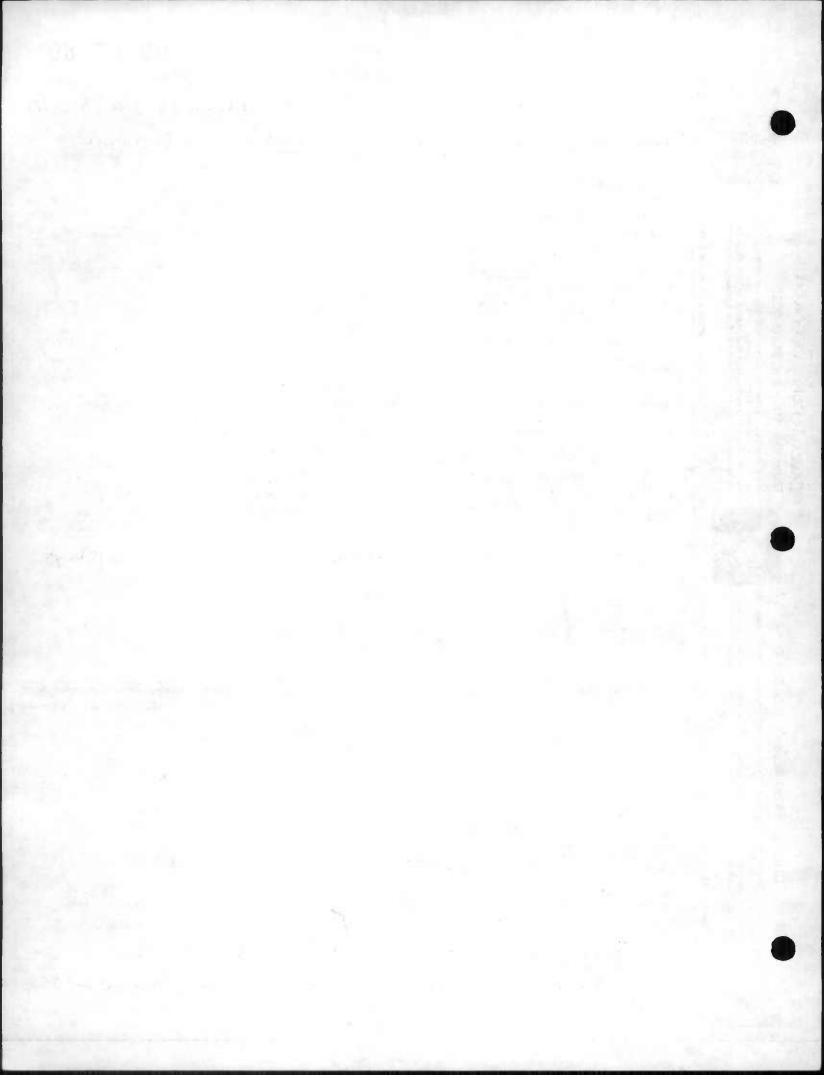
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Bruzdzinski Fruieral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221  20a. Phil Enrich release, or conclusions and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Physician   Middled   Examiner	imore	Pages 1 mant of H ant: If flor ury or oth	1⊠Burial 2 □ Cremetion 3 □ P	emoval from State	cematery, c	rematory or of	har pla		ery 2					
Physician (Madded)  Examiner    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Bail	Departimont any injustral	21. Signature of Funeral Service License	kouske		Bruzdz	ins	ki Fun				. 21	221	
Cause (Disease or influry that influence devents rasulting in death) Last  Due to (or as a consequence of):  d		/Medical Examiner	Immediata Causa (Final diseasa or condition resulting in death)	Cardy	Nooce	lar								
Do go	0,0	axecuted lan end urial-transit		b. Dua to (or as a consequence of):										
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24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Place of Death (Check only one)  25c. Was case referred to medical examiner?  1	P.O.	d by the etached	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying ca	ausa gi	ven in Part I.						
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Section   Sect	>	s cer direc	examiner? 1 ☐ Yas 2⊠ No	lospital:	2 ER/Outpat	ient 3 DO	A Ott	ner				(Specify	v)	
10. Flutt, Ms.  30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)  3508 BANK Street BALtu, Ml 21224	o uoi	ath. :: After the funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Ye						28d. Describe how	injury occurre	d		
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31 Data filed (Identh Dour Voor) 00 Designated Signature		6	0 0	mpleted cause of death	(Item 23a) (Typ		2	4			1			
		State	21 Date filed (Month Day Veed)	32. Registrar's	Signatura	4	Ina	1/2						



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_	1. Decedent's Name (First, Middle,	Last)					2. Dete of D			3. Tima ol Death	
nysician	Bernard George	Buzgierski					Februa	Day 23	2000	8:30PM	
Medical xaminer	la Facility Name (If not institution,	nive street and numbe	r)			4b. City, Town, or			nty of Death	0100.11	
	Franklin Squa	- Hospita	1 Cen	ter		Roseda	ale	Ba	Itimor	مو	
0121021	5. Social Security Number V 6	. Sex 7. /	Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of B			aca (Stata or Foreigny)	
ector	214 03 4341	1 □ MM 2 □ F	83	Yrs.	WOTHING DE	75 Hours Mili	Oct. 9	1916		land	
-	Usual Residence of Decedent  10a. State 10b. County		10- 09	. Town and son	tion				I an	d 11d- On 11 N	
5 -			10c. CR	y, Town or Loca	non				10	ld. Inside City Limits  1 ☐ Yes 2 ☑ No	
현 오	Maryland Baltim	ore		Essex						4	
- 44	10. Countries Tiggeress	Arramina			10f. Zip Code				of What Count	ry?	
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Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 Merried</li> </ol>	12. Was Deceder Armed Forces	57	,5. 13. W	es, specify C	f Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	0- 14. F	lack, White, e		
by F	3 ₩idowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Detes	€. Kuo	10	Yes 2⊠N	lo Specify:		Spec	city: W	hite	
	15. Decedent's			16a Deceder	nt's Usual Occ	runation		16h Kind of	Business/Inde	ustry	
Completed	(Specify only highest	rade completed)		(Give kir	of work do	cupation ne during most of wo ired)	orking	100.14/100.	200110007110	00119	
E	Elementary/Secondary (0-12)	College (1-4o	€ 5+)	Manag				Distillery			
	17. Father's Name (First, Middle, La	st)				18. Mother's Ne	me (First, Middle				
ToB	Unk.					Unk.					
-	19a. Informant's Name/Raiationship	(Type, Print)		19b. Mailing	Address (Stre	et and Number or R	ural Routa Num	ber, City or Tov	m, Stata, Zip	Code)	
0.1	Sylvia Pearce (1	Daughter)		10 S.	Essex	Avenue Ba	altimore	, Md. 2	21221		
	20a. Method of Disposition			Place of Disposit	ion (Name of	place)	Deta	20c. Locatio	n - City or Tov	vn, Stete	
1	1 ☐ Buriat 2 ☑ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe					matory 2/	25/2000	Balti	more,	Md.	
#	21. Signatyle of Funeral Service Lic	ensee /	0	22.1	Neme end Add	dress of Facility			•		
	1 laka W	R. Hour	· Ko		Bruzaz. 1407 o	inski Fund 1d Faster	aral Hon	P.A.	Md 2	21221	
	1407 Old Eastern Avenue Essex, Md. 21221  23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, Approximata Intervel Betwee										
an	Onset end Deeth										
al la	Immediate Cause (Final disease or condition	A	+: -	Pagua					1	0 D	
r	resulting in death)	a Aspir	Due to (	or as a conseque	MODIA				1	0 Days	
9									1		
Examiner	Sequentially list conditions,	b	Due to (c	r as a conseque	nce of):						
Ü	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								F I		
edicai	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):										
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yak	Part II. Other significant conditions	contributing to death	but not res	ulting in the und	erlying cause	given in Pert I.	23b. Did	tobacco uss	contributs to	the causs of death	
Completed by Physician/M							10	Yes 2(30)	3 Prob	ebly 4 □ Unknow	
d b							242 We	s en autopsy	24b. We	ra sutopsy findings	
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ပိ							1	Yes 28 No	1	Yas 2 No	
00	25. Was case referred to medical examiner?	Hospital:			_ [	Other	eth (Check only				
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fica	3 ☐ Suicide 6 ☐ Could not	be one Place of I	niury - At he	ome, lerm, stree			28f. Location	(Street and Nu	mber or Rural	Route Number,	
F	4 Homicide	building,	etc. (Specif	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State)			
0	29a. Certifier 1 Certifying I	Physician: To the bes	at of my kno	wledge, death o	ccurred et the	tima, data and place	e, and due to the	e cause(s) and	mennar as sta	ated.	
edical	(Check only 2   Medical Expone)	aminer: On the basis and manner	of examina	tion and/or inves	stigation, in m	y opinion, death occ	urred at the time	, data and place	e, and dua to	tha cause(s)	
	29b. Signature and title of certifier				29c. Lice	ense number		29d. Data sig	ned (Month, E	Day, Year)	
	> Stillant 1	Vhlas	Λ	0	1 30	RD 198-	796	2/23	200		
	1-11000	- Worker	V 1	220) (Time Pr		/	10	-1-11	00		
3	0. Name and address of person wh	o completed cause of	oeath (nen	1230) (1900, FI	mit)						
0	10. Name and address of person who Pr. Stuart AU	o completed cause of Serman 9	000	ranklir	15aux	re Drive	Baltin	ore Ma	yland	21237	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 1:25a.m FRANCES BROOKS CECELIA FEB 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) HARBOR HOSPITAL If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1□M 2KIF 212-76-4014 96 Yrs. Director MARYLAND **Usual Residence of Decedent** 10c. City, Town or Location 10a Stata 10h County 10d. Inside City Limits 1 ☐ Yas 2 XNo ANNE ARUNDEL GLEN BURNIE Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 6206 FLAMINGO DRIVE 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dales: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Midowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 ahould be filled within hant of Health and Mental Hygiene, art. If Nem 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) 80 MATILDA SHOUDEN CHARLES HINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BURNIE, MARY LAND 2/060 200. Location - City of Town, Stata CARL C. BROOKS, SR /SON 308 CULLIMBUS RO GLEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 12-29-00 BROOKLYN, MARYLAND CALVARY CEMETERY 21. Signature of Funeral Septice Licens 22. Nama and Address of Facility NUTTER FUNERAL HOMES, INC 2501 GWYNNS FALLS PREYWAY

BALTIMARE, MARYLAND 21216

23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac br raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** /Medical Immediate Cause (Final severe koys disease or condition resulting in death) Examine Physician/Medical Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Gastrointestinal Bleeding 1 Yes 2 Probably 4 Unknown Records. þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed Dementiq completion of cause of death? 1 ☐ Yas 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Division Attending 1 DNatural 5 Pending investigation death. 1 Yes 2 No n 24 hours after death. Ne Funeral Director: A plataly filled in by the fi 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 6 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

0/0:1 31. Data filed (Month, Day, Year)

FEB 2 8 2000

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Avenue Baltimore, Md

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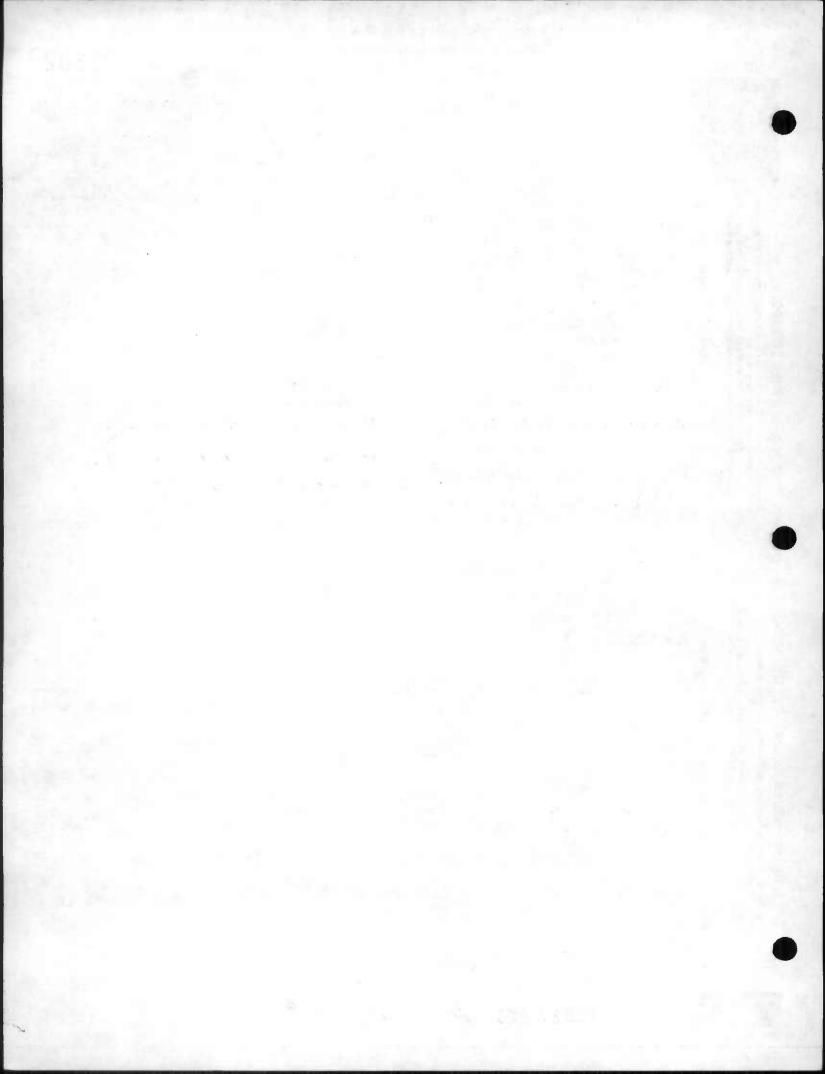
32. Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rep No 0 0 5382

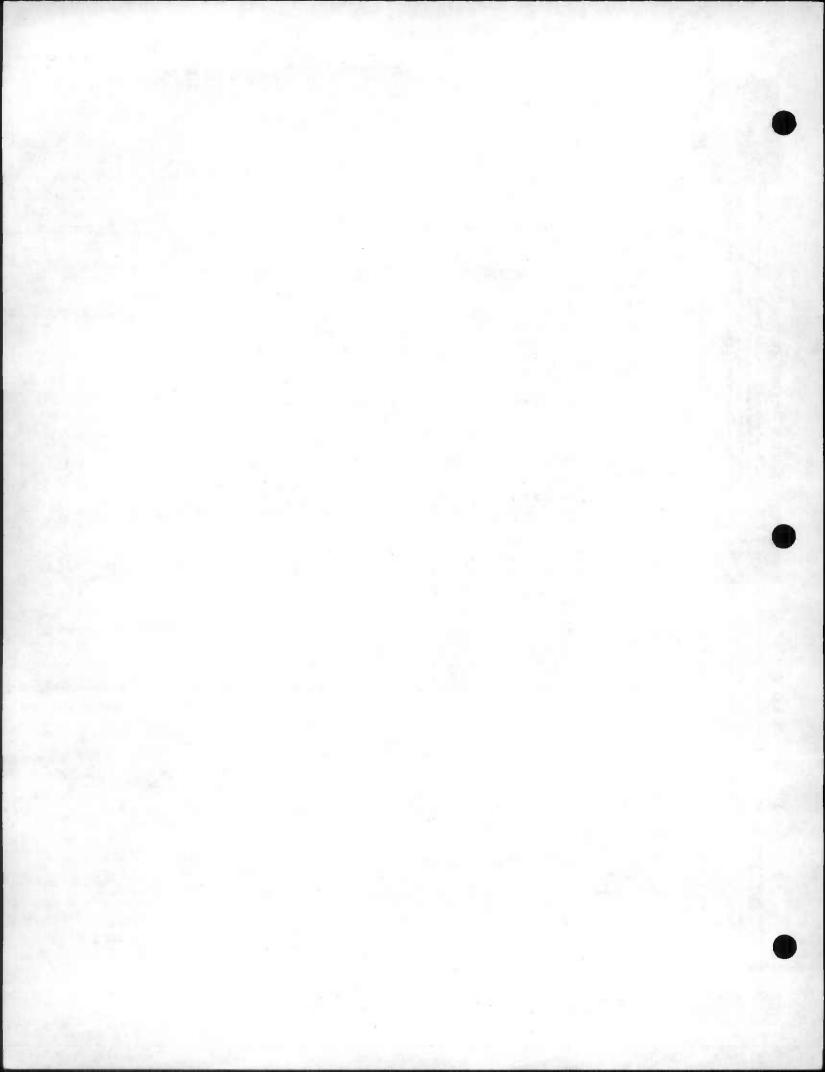
					Cen	tificate	e of Death		Reg. No	UU	063	102		
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xaminer	4a Facility Nama	a (If not institution, giv	e street and number	)			4b. City, Tow	n, or Location of D	eath 4	c. County	of Death			
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neral ector	5. Social Security 214-62-	9718	ax 7. A □ M 2□ F	ga (In yrs. le 94	ast birthday) _ Yrs.	If Under Months	1 Year If Under 2 Deys Hours	Min. 8. Date of (Month)	Birth Dev. Year 12 19	06	9. Birthplace ( Country) Maryla			
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acm.	19a. Informant's	Neme/Relationship (	Type, Print)		19b. Maiting	g Address	(Street end Number	or Rurel Route Nu	imber, City	or Town,	State, Zip Code	1)		
1		E. Cooney	7, Jr. (so				oughy Rd.				21234			
or oth	20a. Method of D	isposition 2 Cremation 3 C	Demoval from State	20b. Pla	ace of Dispos metery, crem-	sition (Nem	ne of thar piece)	Data	20c. L	ocation - (	City or Town, S	itate		
Injury o		n 5 Other (Specify			aney V	alle	y Mem. Gro	dns. 2/26	2000	Ti	monium,	MD.		
E S	Dulaney Valley Mem. Grdns. 2/26/2000 Time Specify Dulaney Valley Mem. Grdns. 2/26/2000 Time Ruck Towson Funeral Home, Inc.													
£ 8	Dil	' (	( 2	00			York Rd.							
- 4	23a Part Ente	or the disease, or comeant feilure. List only	plications that cause	d the death	. Do not ente	or the mod	e of dying, such as c	ardiac or respireto	ry errest,	1207	Appr	oximete		
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State of Maryland / Department of Health and Mental Hygiene 0 0 6 3 8 3

	Certificate of Death	Re	eg. No.		
	Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death	
Physician /Medical	JOSIP CALETA	Februar	y 24, 200	0 10:30 AM	
Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	4c. County of De	ath	
	Manor Care Towson Towson			imore	
Funeral Director	5. Social Security Number  212-70-5356  Usual Residence of Decedent  6. Sex 1		Year) 9. Bi 1909 Yu	nthplace (State or Foreign Country) goslavia	
and tand	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
after death with the Meryland or items 23s or 28s-f show colors must be notified at Funeral Director	Md. Baltimore Sparks  10e. Street and Number 10f. Zip Code	10	Og. Citizen of What C	1 ☐ Yas 2 ☒ No	
Wild Will	14205 Quail Creek Way Apt. 304 21152		Yugoslavi		
Jeath Tre 2:	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue		14. Race - Am		
urs after	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:	rto Rican, etc.)	Specify:	Specify: White	
n 72 hours netural', or leted by	15. Decedent's Education 16a. Decedent's Usual Occupation	adding.	16b. Kind of Busines		
c ' = -	(Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [Elementary/Secondary (0-12)   College (1-4or 5+)	orking			
filed with Hygiene. ther ther ent, the	Self employed	0=0	Grocer		
d out H	17. Father's Name (First, Middle, Last)  18. Mother's Na  Moddle, Last)	ame (First, Middle, M		abic	
2 should and Men is marke aurmatic	19e. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Fi	Rural Route Number	City or Town, State,	Zip Code)	
1 and 2 Health a em 27 la ither trai	Magda Caleta/daughter 14205 Quail Creek Way	Apt. 304	Sparks, M	d. 21152	
of He of He r offh	20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)	Date	20c. Location - City o	r Town, Stata	
Pages net of mr. if its iry or o	1 Bunal 2 Normation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp.	2/25/00	Towson,	Md.	
permit. Pages 1 and 2 s Department of Health ar Important: if them 27 ta any injury or other trau- pace.	21. Signature of Eugeral Service Leansee 22. Name and Address of Facility Ruck Towson Funer		Inc.		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	son, Md. 2	21204	Approximate	
esth certificate be associted attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):				
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s been 2 shoul		24a. Was an perform		. Were autopsy findings available prior to completion of cause of death?	
The lev ate hes pege 2		1 □ Ya	s 20 No	1 Yes 20 No	
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ling Phy After thi funeral funeral	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 26b. Time of Injury Work?  2 Accident investigation  28a. Date of Injury 26b. Time of Injury 1 Work?  1 Yes 2 No	-	ow injury occurred		
of Spirate	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fam. Breet, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,	
Hospit 4 hour Funer lely fill	29a. Certifler (Check only one)  12 Centrying Physician: To the best of my knowledge batty occurred at the time, date and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and reference stated.	ce, and due to the co curred at the time, do	suse(s) and manner a ste and place, and do	as stated ue to the cause(s)	
within 2 To the comple	29b. Signature and title of certified 29c. License number	2	9d. Date signed (Mor	nth, Day, Year)	
- > - 0	· / // 17 Vel 14273	6	2 - 29	5-00	
9	30. Name and address of person who/completed cause of description (1909). Print)  AYMAN AKKAD 7600 OSEX DR #411	Touson	2-29 Md. 5	21204	
State Registrar	St. Date filed (Month Day, Your) 32. Refrigerate Stortefure Stortefure				



State of Maryland / Department of Health and Mental Hygiene 06384 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Floyd A. Cardwell February 27, 2000 10:50 p.m. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 325 Savannah Road Essex Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Yrs 244-38-7546 70 Director June 30, 1929 North Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 284-4 Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? b 325 Savannah Road 21221 U.S.A. Berns 23e Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck Whita atc filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Detes: 1 Never Married 2☑ Merried Baltimore, Maryland 21215-0020 "natural", or WWTT 1 Yes 2 No Specify: Specify: àq 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Superintendant Can Manufacturer 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant; If Item 27 is marked off lury or other traumatic even Be Albert Cardwell Nettie Viola Bumgardner To 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) important: If lism 27 is n any injury or other traum Marie Cardwell (wife) 325 Savannah Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3/1/2000 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast shock, or heart lailure. List only one cause on each line. Approximata Interval Batween Onset end Death **Physician** /Medical Immediate Cause (Finel 48 6 cm th disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical Due to (or as a consequence of): 88 for use as signed by the aid be detached if P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Records. p 24b. Wara autopsy lindings eveilable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 1□ Yes 2DNo certificata 1 Yas 2 No Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Statesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident efter death Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 3 4 Homicide Hospital or 124 hours eff
 Funeral Differely filled in 19 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and menner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of person who completed cause of death (ttem 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

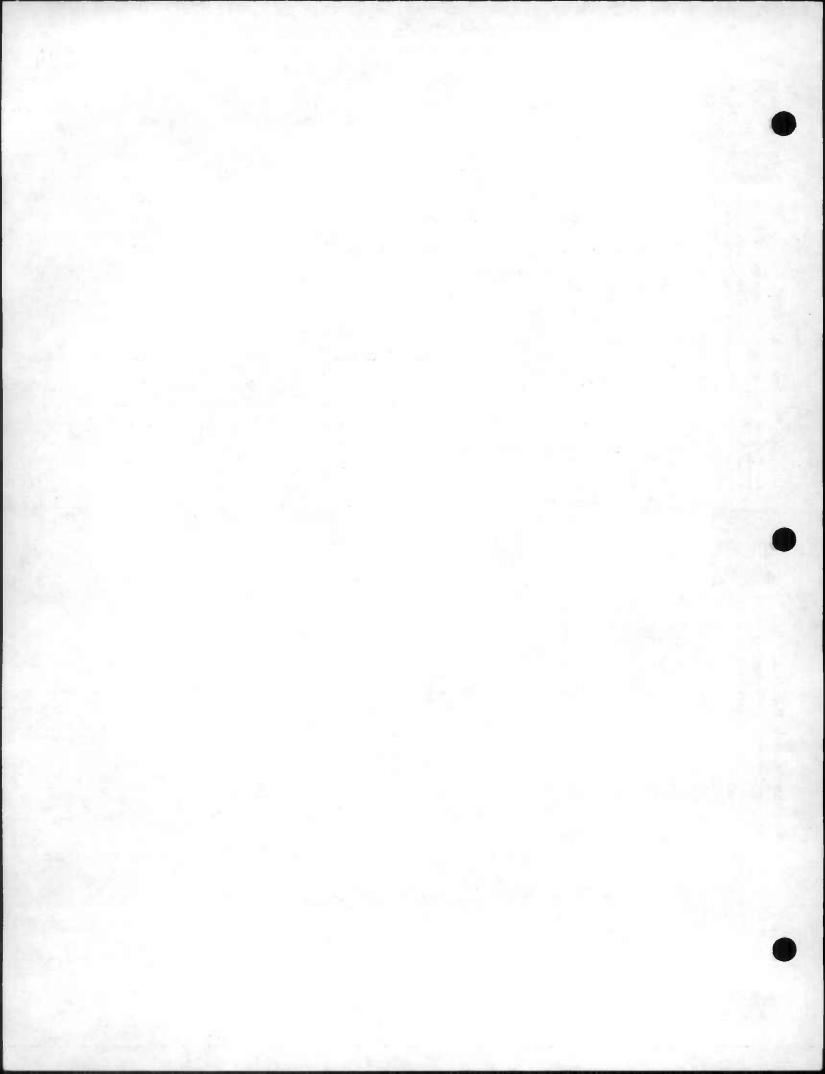
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THANT EB2 8 6830 HOSPITAL DRIVE, SWITE 206

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32. Régistrar's Signature

BALTO



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06385 Certificate of Death 3. Time of Death 1. Decedent Name (First, Middle, Last) 2. Data of Death Day **Physician** 4b. City, Town, or Location of Death 4c. County of Death 252714 10 /Medical 4a Facility Name (If not institution, giva street and number) Examiner St. Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Sept. 23, 1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Days Hours 78 064 16 0276 Yrs. Director New York Usual Residence of Deceden the Maryland 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nant of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or item 23s or 28s-f show ary or other traumatic event, the Modical Examiner man be notified. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 32 Dunvale Rd. "Apt 303" 21204 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No if Yes, Give Year or Dates: 13. Was Dacedeni of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Never Married 2 ☑ Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Library 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Julia Unk. Torello Battaglini 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, informant's Name/Relationship (Type, Print) Julie Pierson (Daughter) 1119 Coldspring Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State Department of Important: if any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 2/26/2000 Baltimore, Md. 22. Name and Address of Facility M.Funeral Service Lic Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Entire the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Diralan disease or condition resulting in death) Examine Examiner physician and the burial-transit be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of) 6/113 P Box 68760. Physician/Medical thet the death certificata Dua to (or as e consequence of) for use es ppen Traches 0/Le TYLYZ ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o signed by d 1 Yas 2 No 3 Probably 4 → Thknown Division of Vital Records. þ law requires 24b. Were autopsy findings available prior to should I Completed 24a. Wes an autopsy completion of ceuse of death? s certificate has b The 1 Yes 2 No 1 Yes 2 No After this certifical funeral director. i or Attending Physician: after deeth. Be 25. Wes cese referred to medical 26. Place of Death (Check only one) examinar? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injuryoc 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netwat 5 Pending 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 ☐ Yes 2 PHO Investigation 2 Accident 100 6 123 by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) n 24 hours attar he Funeral Dirac 4 ☐ Homicide 32 Dunuale R lourson Mo Hospital edicai 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

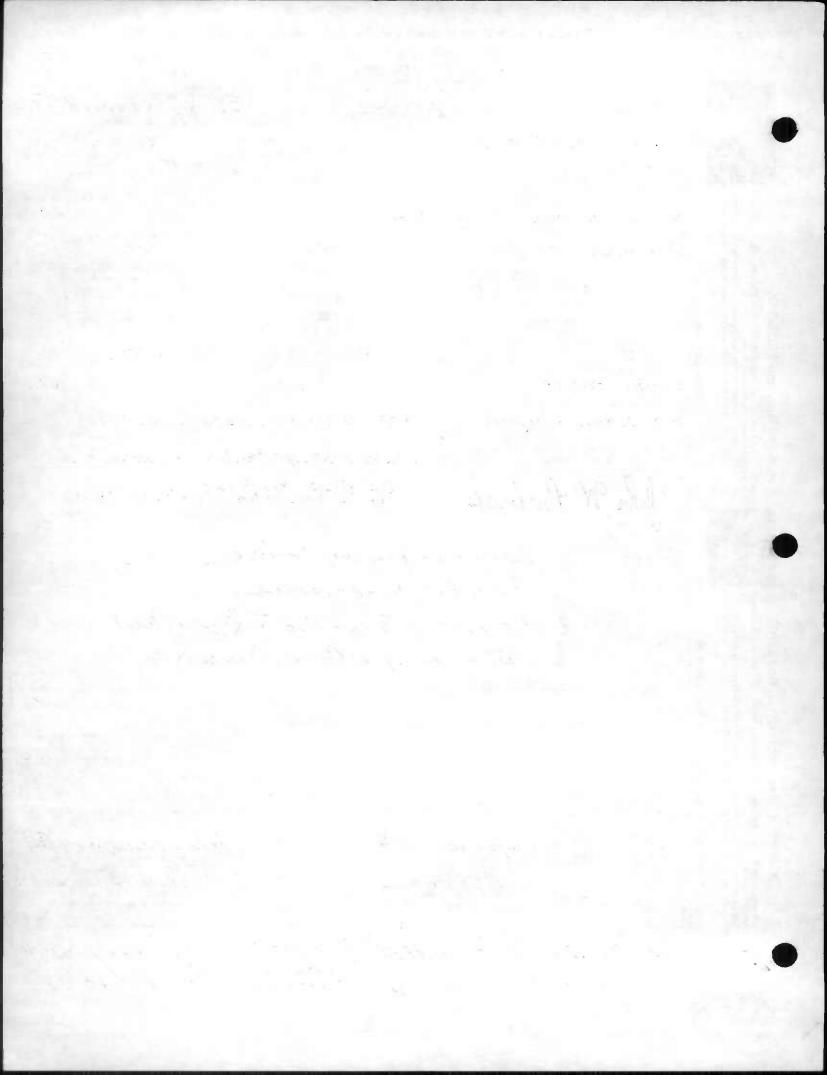
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the To the Complet 29c. License number 29d. Dete signed (Month, Dev. Year, 29b. Signatura and title of certifier 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) ONNO//M harles 31. Date filed (Month, Day, Yeer)

State Registrar

**DHMH 16 Rev 6/95** 

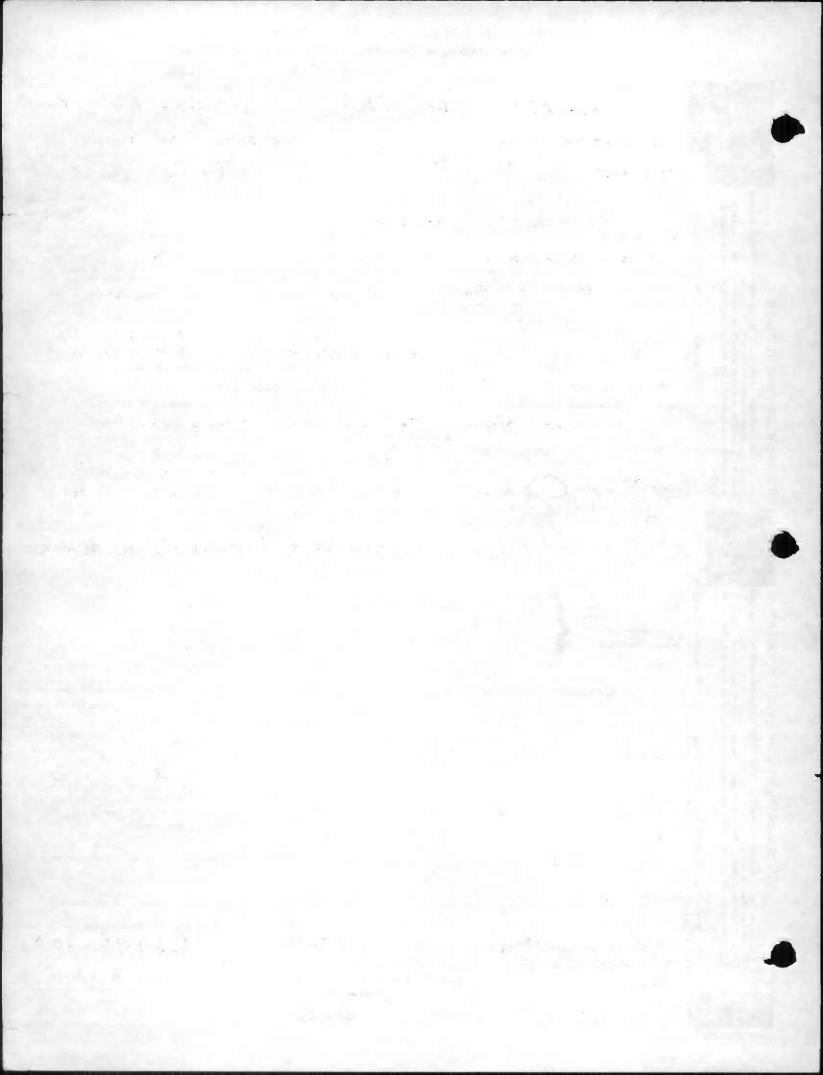
FEB 2 8 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) Month FEBUARY DRCORAN **Physician** 1 Pm UDRE 23 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 X X Yrs. 06/03/1922 Maryland **Director** 215.12.0167 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner mant is notified. 1 Yes 2 No Directo MD Anne Arundel Linthicum 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 534 Forrestview Road 21090 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☑ Xio If Yes, Give Year or Dates: 1 Never Married 20 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Great Atlantic & Elementary/Secondery (0-12) College (1-4or 5+) Pacific Tea Co. Administrative Clerk 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 Carol Stivers Lottie Jones 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 534 Forrestview Rd., Linthicum, MD 21090 Evelyn Corcoran - Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition WBurial 2 ☐ Cremation 3 ☐ Removal from State 02/26/00 4 Donation 5 DOther (Specify) Loudon Park Cemeterv Baltimore, MD Sports Funeral Service L 22. Name end Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 Kelly Gregory Fink Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, or heart feilure. List only one cause on each line. · CHRONIC OBSTRUCTIVE PULMONARY DISGRE YEARS **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner g physician and as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) that the death certificate be avecu Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 1₽Yes 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed is certificate has director, page 2 1 Yes 28 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetlent 3 DOA 1 Yes 2 No 2 this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Netural 2 Accident 5 Pending investigation rector: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Direc 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 140491 - Rigz 800 Novia Hammonds, FELLY Rd Lin7 Heum 21090 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Yed M. A 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature FEB 2 8 2000 Depensi Registrar



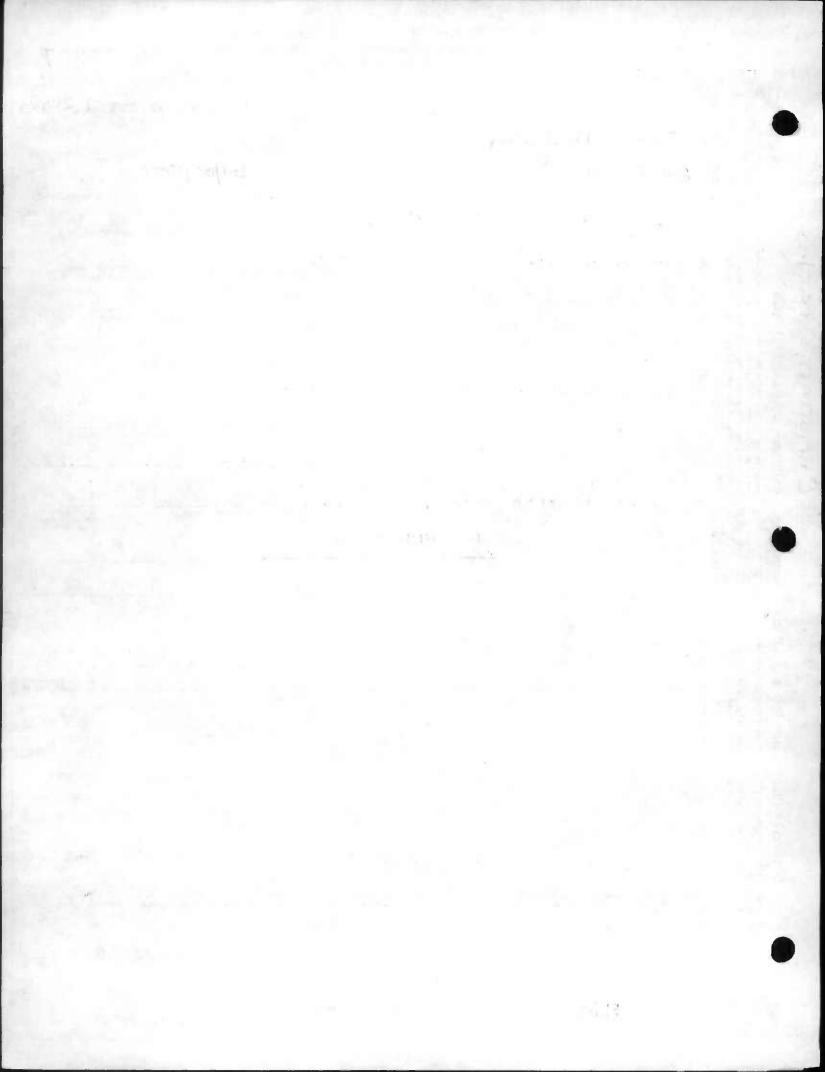
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #23a PER MD G780 2/28/2000 AH Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** February 20, 2000 2', 20pm cation of Death Charles Christian /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HOSPITA SINON If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 15 M 2□ F Yrs. 212706424 Usual Residence of Decedent Director 42 M.D. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show TY Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 8 2611 Whitney 21215 U.S.A. Funeral Nems Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mentel Status 1 ☐ Yes ZX No If Yes, Give Yeer or Dates: "natural", or h 1X Never Merried 2 Merried 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade 17. Father's Neme (First, Middle, Last) Laborer Various Jobs 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental HUSTIA 2 Douglas Christian Ruth Thomas 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -2611 Whitney Ave, Baltimpre Md Ruth H. T. Christian 21215 altimore. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 8 Burlel 2 □ Cremetion 3 □ Removel from Stete 6 **Department** Woodlawn Cemetery
22. Name end Address of Fecility 2-26-00 Baltimore Co., Md 21. Signature of Foneral Service Ligensee March F/H West 4300 Wabash Ave, Baltimo Do not enter the mode of dying, such es cardiac or respiratory arrest, Baltimore Md 21215 234 Fart1. Enter the disease, or combilications that caused the deeth.

h, k, or heer tailure. List only the cause on each line. Approximete Intervel Between Onset end Death **Physician** IMMUNODEFICIENCY /Medical immediete Ceuse (Finel disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): 68760 n04572 Physician/Medical The law requires that the death certificate Due to (or es e consequence of): Box 980 signed by the a Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed pege 2 1 Yes 2 No 1 ☐ Yes 2☐ No certificate of Vital funeral director, 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 22 No this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury et Work? Division Affer 5 Pending investigation Attending 1 Netural after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 3 4 Homlcide 6 24 hours tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

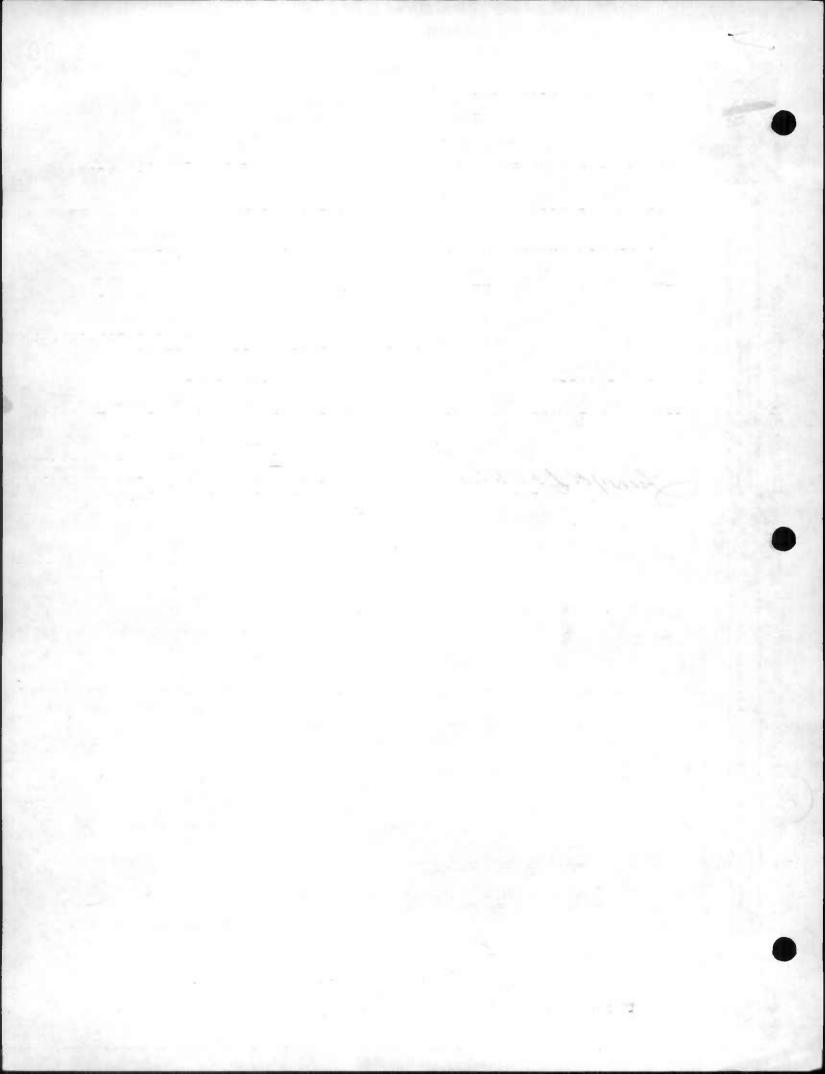
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29a. Cartifier completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) Towald Arous Belyadory Aud W 31. Dete tiled (Month, Day, Year) FEB 2 8 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar



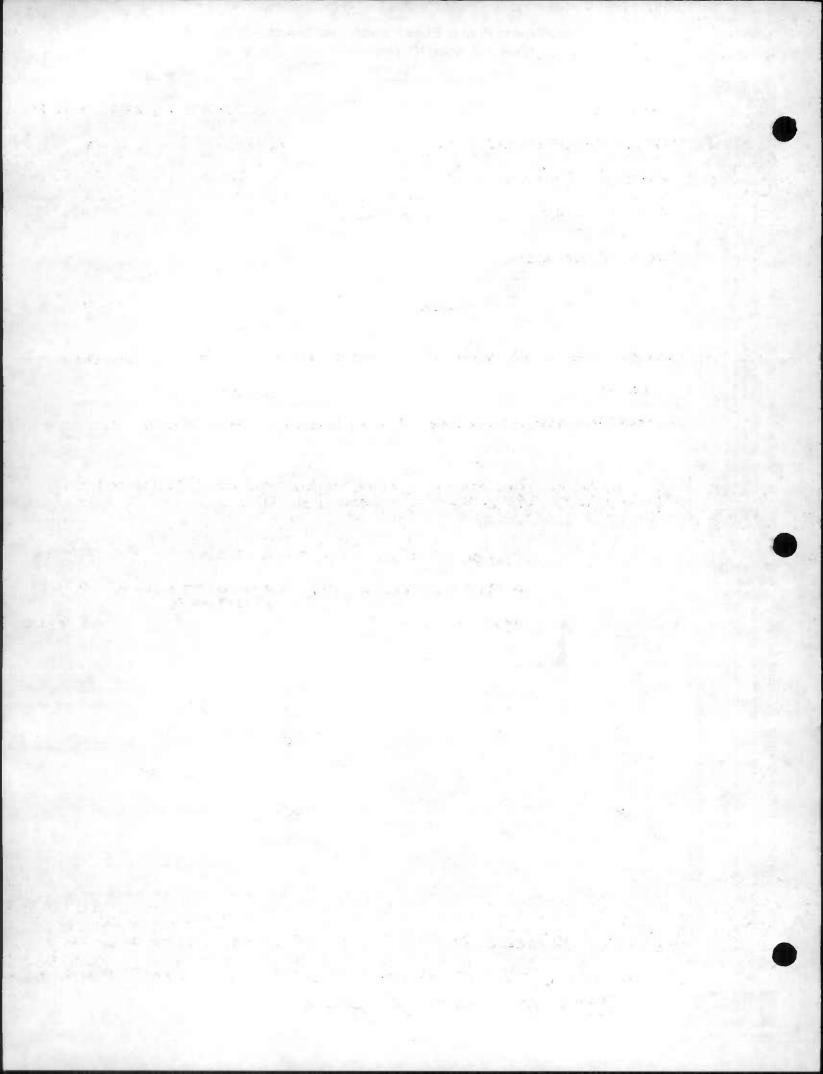
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alt.	Department Important: H eny injury or page	21. Signature of Funeral Seculor Lice	Theirs		22. Name and Add	dress of Facility	FT N			FUNERAL HI
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State of Maryland / Department of Health and Mental Hygiene 0 0 6 3 8 9

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tor	216-16-0815 Usuel Rasidence of Decedent	1⊠M 2□F	74	Yrs. Months	S Deys Hours		6, 1925	MD
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ctor	MD	/A		Baltimo	re			tv Yes 2 □ No
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To	unknown					unknown		
	19e. Informent's Name/Relationship	(Type, Print)	19b	. Mailing Addre	ss (Street end Numb	er or Rural Route Nu	mber, City or Town, S	Stete, Zip Code)
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To Be Compl	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control o		20b. Piace of cemeter	Disposition (N ry, cremetory of	ame of	Date	20c. Location - (	City or Town, State
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DHMH 16 Ray 6/95



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If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White p 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hyglen Important: If Item 27 is marked other that any filury or other treumatic svent, that phice. Delievery Printing Company Person 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles E. Corson Ivia Nora Whitesell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) sister-inlaw Anna Bartholomey 155 South Grundy Street, Baltimore, Maryland 21224 Apt. 132 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State stery, crematory or other place) 1 ₺ Burial 2 Cramation 3 Removal from Stata 2/26/2000Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 21. Signature of Funaral Service Licenses 263 S. Conkling Street, Baltimore, Maryland 21224 services 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 20 Examiner Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Due to (or as a consequence of): for use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 2 No 1 Yee 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s Jas 20 MG certificate 21 Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 200 No Other: Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affar Natural 5 Pending 1 Yes 2 No death. Accident invastigetion 24 hours after deat Funeral Director: 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my anision death account. 29a. Certifier edicai To the Hosp within 24 hor To the Fune completaly fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura 29c. License number

State Registrar 30. Name and address of person.

31. Date filed (Month, Day, Year)
FEB 2 8

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2000

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

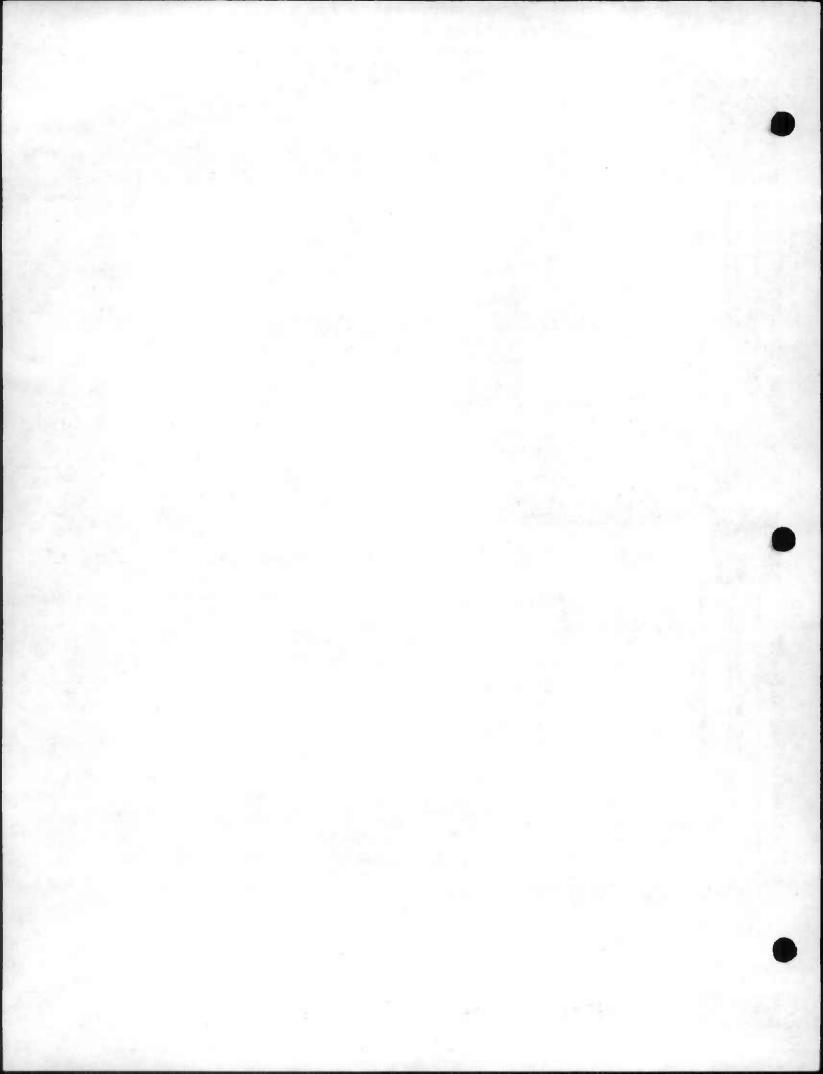
Box 68760,

Division of Vital Records, P.O.

the completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

101



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 06391 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death

Physician
/Medical
Examiner

DO Division of Vital Records.

	edical miner	ANNIE LOUISE  4a. Facility Nama (If not institution, given to the second	va street end number)		21	1	Location of Daath	4c. County	2000 2140 of Daeth
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the Maryland		10e. State 10b. County Marylono Anne An		y, Town or Loca					10d. Inside City Limits
with the Mi	Directo	10e. Street end Number	BEACH RUA		10f. Zip Code	403		10g. Citizen of V	Whet Country?
urs efter death	by Funeral	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in U, Armed Forças?  1	S. 13. We	s Dacedent of H		Specify Yas or No- to Rican, atc.)	14. Rac	e - American Indien, ck, White, atc.
J within 72 hou jiana.	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed)  Collaga (1-4or 5+)	(Give kir. lifa. DO	nt's Usuel Occup nd of work done NOT use retired	during most of wo d)	orking	BAIHM	usiness/industry
uld be filed fantal Hyg rkad other tic event,	To Be C	17. Fether's Name (First, Middle, Last	MIARO			ALICE		won	
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the d	by Physici	Pert II. Other significant conditions of	ontributing to daeth but not resu	ulting in tha unde	orlying cause give	an in Part I.	23b. Did t		ntribute to the cause of death?
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nysician: nis certifical i director,	To Be Comple	25. Was case referred to medical axaminer?  1 ✓ Yes 2 □ No	Hospitel: 1   inpatient 2   1	ER/Outpetient	3□ DOA Oth	ar-	1 □ Y eth (Check only on forma 5 🖾 Resid	16)	
<ul> <li>Hospital or Attending Physician: The law requigations after death.</li> <li>Funeral Director: After this certificate has been etely filled in by the funeral director, page 2 should</li> </ul>	o Be	axaminer?	28a. Deta of Injury (Month, Day Year)	ER/Outpetient 28b. Time of Injury	28c. injun	er: 4 Nursing F	eth (Check only or	ne) ence 8 □Othe	er (Specify)

cause of deeth (Item 23a) (Type, Print)

TONES, MO

State Registrar 29b. Signature end title of certifiar

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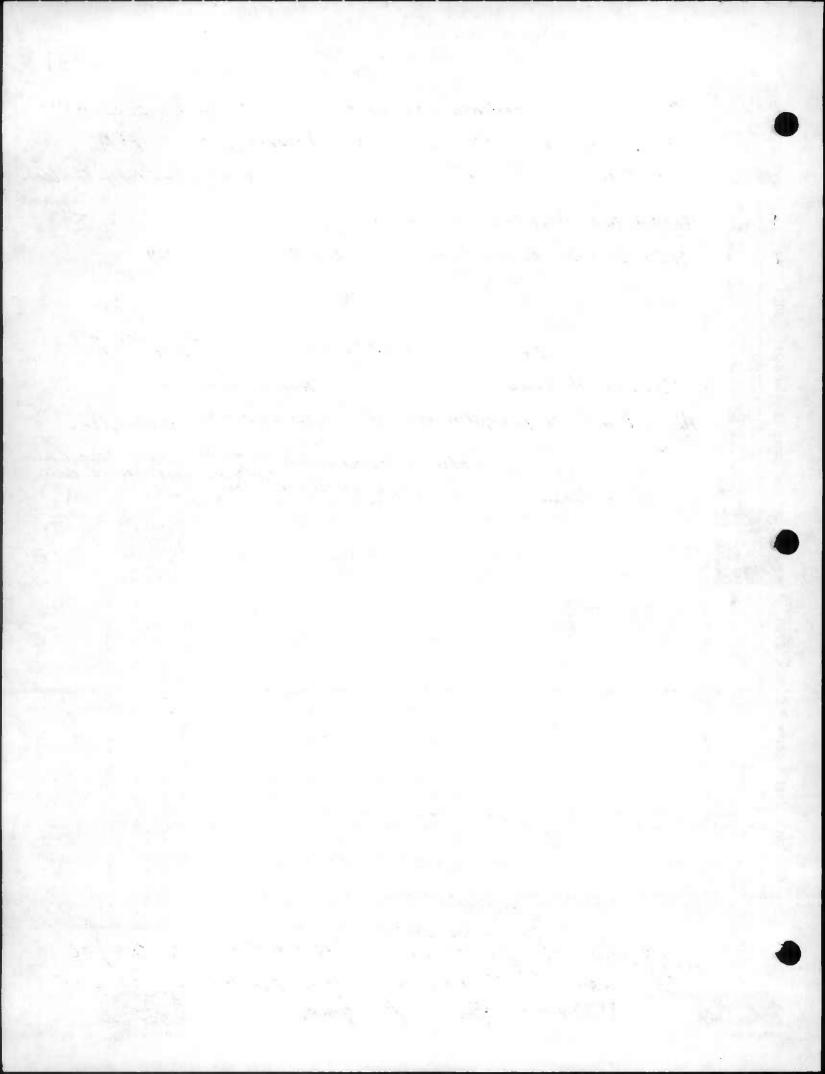
DHMH 16 Rev 6/95

29d. Data signed (Month, Dey, Year)

29c. License number

695 America

Contina Inside City Limits



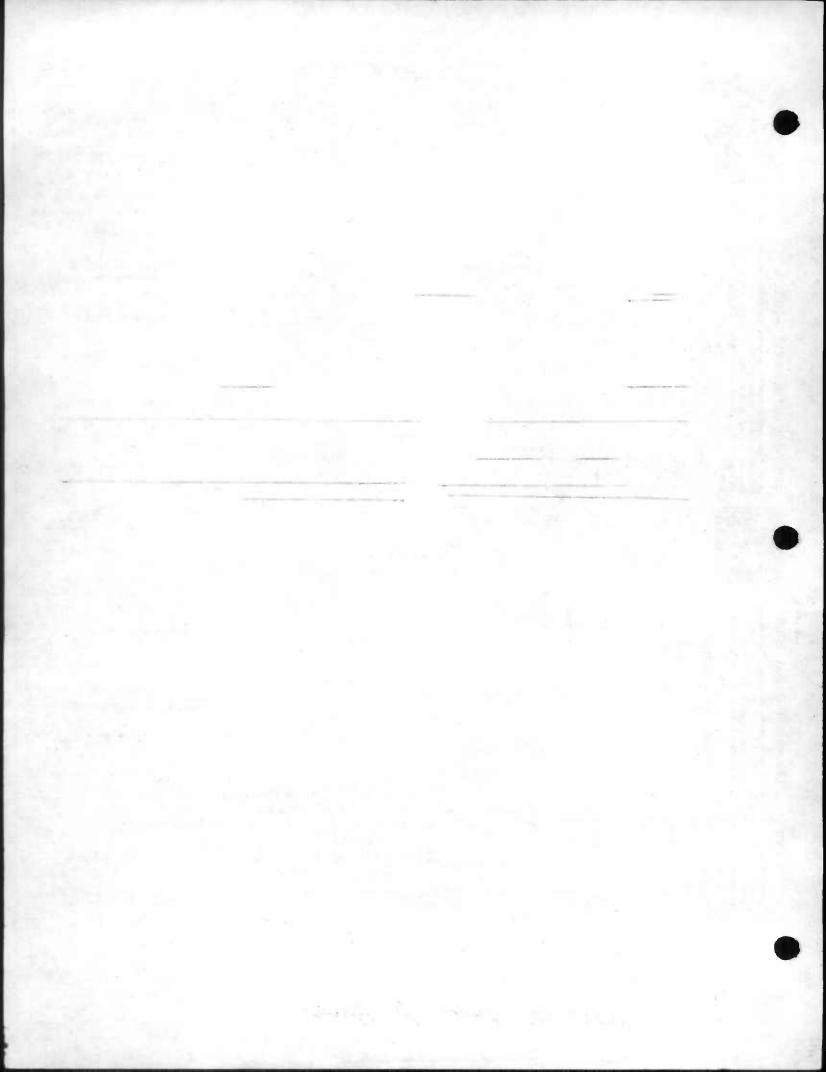
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS 11,12,17-22 PER FH G781 3/24/2000 AH Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 3029E CHAI STENSEN HAMMER FEB 4 22=544 2000 4e Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 22 HARFORD MEMORAL HOSPITAL HAURE DE GRACE HARFOUD 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Date of Birth August | 8. Birthplace (Stata or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 1⊠M 2□F Director 214-54-4841 Denmark Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Churchville Harford 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 21028 111 Calvary Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status Bleck, While, etc. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 21215-0020 1 ☐ Yes 2 ☑ No Specify: unknown Specify: 3 Wildowed 4 ☐ Divorced white Completed 16a. Decedent's Usuet Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 0 Elementery/Secondery (0-12) College (1-4or 5+) machinest military 17. Falher's Neme (First, Middle, Last) VICTOR HAMMER CHRISTENSEN 18. Mother's Name (First, Middle, Maiden Surnama)
SVENBORG MARIE PETERSEN Maryland Be 8 Mental Pages 1 and 2 should 19e. Informent's Neme/Reletionship (Type, Print)
DEBORAH, E. BASH/DAUGHTER
HARTONG Memory 2 L HOSPIT 19b, Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
1901 WHEEL RD., BEL AIR, MD 21015
501 A. Union Abve Havie de Glace, MD 21074 IN LAW Baltimore, BRUARY 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Dele 20c. Location - City or Town, State 8 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State HILLTOP SERVICE CORP. 4 □ Donation 3 □Other (Specify) In G 12/25/00 TOWSON, MARYLAND 21. Signature of Funeral Service Licensee HOWARD K McCOMAS, IV 22. Name end Address of Fecility McCOMAS FUNERAL HOME CP A 212011317 ROAD MD 21009 12 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximele Intervel Between Onset end Deeth **Physician** /Medical Immediele Ceuse (Finel ASCUID diseese or condition resulting in deeth) Examiner Examiner W 57 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Bon 73 68760. Physician/Medical Due to (or es a consequence of): Box Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? o. 1 Yes 2 No 3 Probably 4 Unknown 4 þ Vital Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed certificate 1 Yes 25 Yo funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ topalient 2 ☐ ER/Outpatient 3 ☐ DOA 110 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To to this 27. Menner of Daalh 28e. Dele of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 1 Neturel 5 Pending deeth. investigation 1 Yes 2 No 2 Accident affor Attend after deeth Director: the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stelled. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 2000 DME 30. Neme and address of person who completed cause of death (ttem 23a) (Type, Print) GPUA BHN 218 FULLOND NE SELAN MD 21014 31. Dele flied (Month, Day, Year) 32. Regiştrer's Signeture State

DHMH 16 Rev 6/95

Registrar

FEB28



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death February 23, 2000 Leonard Wilson DeMoss, Sr. 11:00 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cromwell Center Parkville Baltimore Co. If Under 1 Yee If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 215-07-0790 86 January 12, 1914 Lutherville, Md. Usual Residence of Decedent 10a. Siate 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Baltimore Co. Towson Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8622 Drumwood Road 21286 United States of America 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
if Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Food Service/ Elementary/Secondery (0-12) College (1-4or 5+) 07 Restaurateur Self Employed n/a 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Edgar Joel DeMoss Laura Augusta Ohler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Ethel DeMoss(nee Ward)(Wife) 8622 Drumwood Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens, 02/26/2000 Timonium, Maryland 21. Signeture of Fungerah Service Licensee Jeffrey L. Gair 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 For complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause of much line. 23a. Part Enter the disease shock, of hear failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): HEART FAILURE ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that britished executions) Due to (or as a consequence of): thet initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 thenknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 100 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner certificate be executed Box 68760, P.O. Records, of Vital Division or Attending t hours after death. uners! Director: After sky filled in by the fun

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

8 Items 23a

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**Physician** 

/Medical

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Baltimore, Maryland 21215-0020

death

the Medical Examiner must be notified at

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To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by edical Registrar

**DHMH 16 Rev 6/95** 

State

29b. Signature and Atle of certifier eo des 29c. License number D52228

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stelled. 29d. Date signed (Month, Dey, Year)

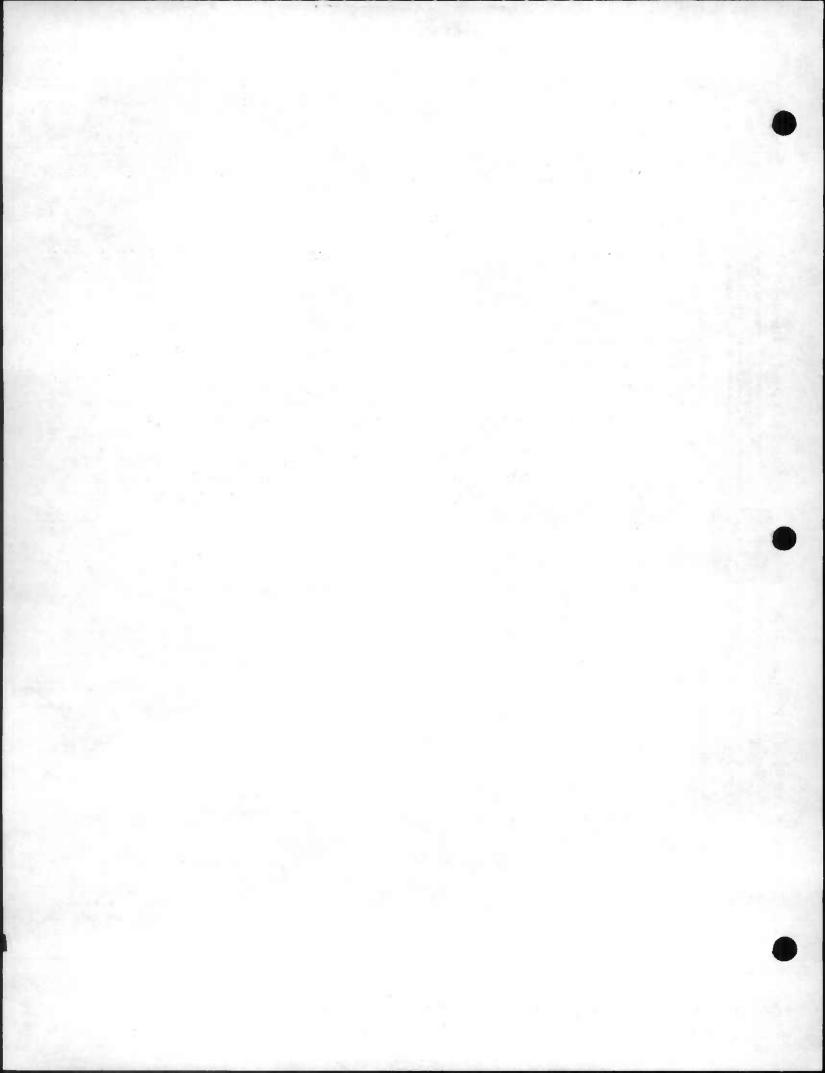
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3007 E. MORTHERN PKWY BALTIMORE, MD 21214 PSHALODIYA MD MULKIMAR

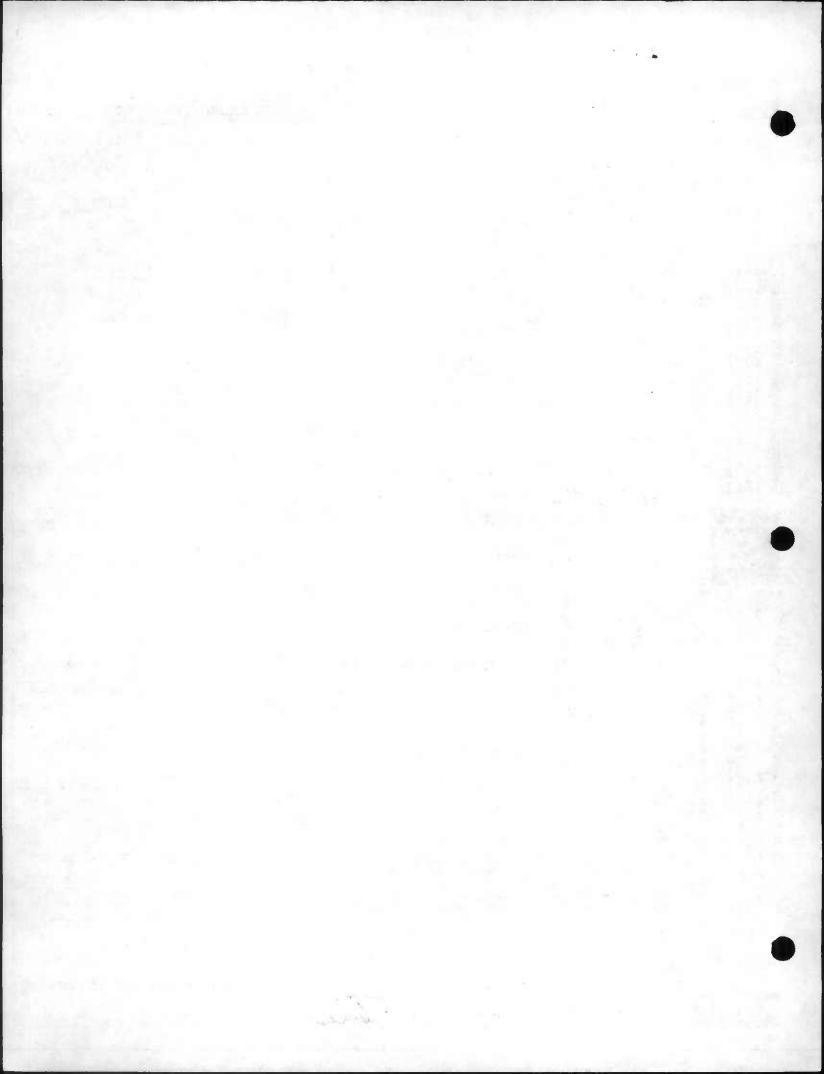
31. Daje filed (Month, Day, Year) 32. Registrar's Signature FEB28

10 certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Nancy Lee Dew 24 2000 4c. County of Death FEBRUARY 2000 12:19 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) June 27, 1932 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 67 Yrs 215-30-7684 West Virginia Director Usuai Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or itsems 23s or 28s-f show 1 TYAS 2KINO Maryland Baltimore Monkton 10e. Streal and Number 10f. Zio Code 10g. Citizen of What Country? 늄 15920 Carroll Road 21111 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No If Yes, Give Year or Datas: 1 Yes 2 No Specify: altimore, Maryland 21215-0020 White Specific p 3 Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 17. Falher's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Department of Health and Montal Important: If Nem 27 is marked or any injury or other traumatic ever DRGs. Lo Frank Bailey Virginia Martin 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bailey Dew / Daughter 1339 Corbett Road Monkton, MD 21111 20b. Placa of Disposition (Name of cematery, cremetory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 2/26/00 Towson, Maryland 22. Name and Address of Facility Leonard J. Ruck, Service Leansee Timothy Harman Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ISCHEMIC BOWEL HOURS disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner MESENTERIC ARTERY OCCLUSION DAYS certificate be executed physician and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thei initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 RENAL FAILURE DAYS Physician/Medical the Due to (or as a consequence of) ISCHEMIC CARDIOMYOPATHY YEARS P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 4 Unknown 1 Yes 2 No 3 Probably CORONARY ARTERY DISEASE Records. P 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? LACTIC ACIDOSIS completion of cause of death? ate has page 2: PERIPHERAL VASCULAR DISEASE 1 Yes 200 No 1 Yes 2 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpalient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28b Time of 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 1) Neturel A hours after des.

-rail Director: After 'in by the fir 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 🗺 Certifying Physician: To lhe best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signalura and title of cartifier W 29c. License number MHICHM D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE, TOWSON, MARYLAND 21204 RICHARD LINTHICUM, M. D. , 7601 31. Date filed (Month, Dey, Xear) FEB 2 8 2000 32. Registrar's Signature State Papera Registrar

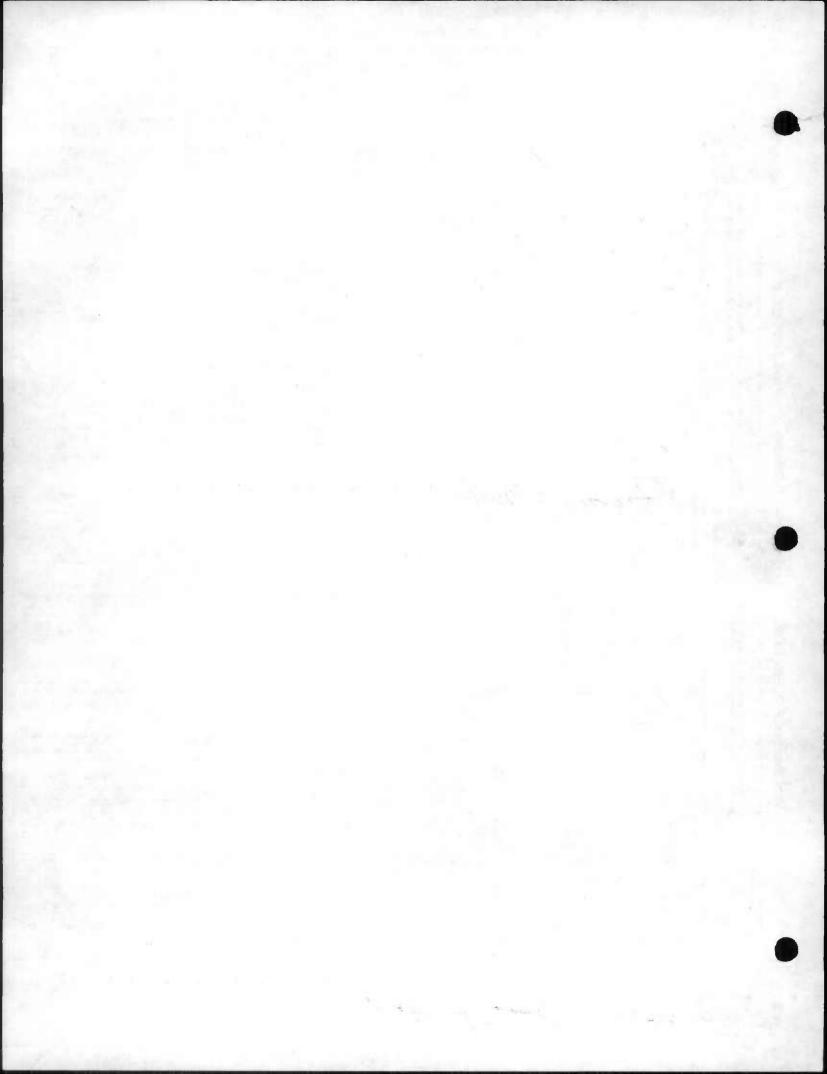


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NID	ESALES  1. Decedent's Name (First, Middle, Le	ist)		Cer	tificate of	Dealli	2. Date of De	Reg. No.		ime of Death
sician ledical	Anthony Gerard I						Month FEB.	Day	Year	1548 PM
miner	4a Fecility Neme (If not institution, given 2029 EAST LON		•			4b. City, Town, or BALTIM	Location of Deat		of Death	
eral tor	5. Social Security Number 6. 9		age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th		State or Foreign
	Usual Residence of Decedent  10a. Stete 10b. County		10c City	Town or Lo	cation					side City Limits
lor lor	* /	/ n		imore						Yes 2 No
Directo	Maryland N/ 10e. Street and Number	A	Daic	THOLE	10f. Zip Code			10g. Citizen of V	Vhat Country?	
al D	2029 E. Lombard S	Street			21231			USA		
by Funeral Director	11. Merital Status  1. Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 If If Yes, Give Year or Detes	No.		Ves Decedent of I i Yes, specify Cub I Ves 25 No	lispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Raci Blac Specify	e - American Ind k, White, etc. White	lian,
Completed	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)	ducation		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Bu	siness/Industry	
Com		1		Arti	st			Art		
To Be	17. Father's Neme (First, Middle, Last Gaetano DeSales					Genevie	ve Sokol			
	19e. Informent's Name/Relationship ( Anita Korpisz	Type, Print)			g Address (Street Linwood					
	20a. Method of Disposition		OOM	e of Dispo	sition (Name of netory or other place		Date		City or Town, Si	
	1  Buriai 2  Cremetion 3  C 4  Donetion 5  Other (Special		8		ry Cemet		2/28/00	Baltim	ore, Mar	ryland
an al	23e. Part1. Enter the diseese, or color shock, or heert feilure. List only Immediate Causa (Final diseese or condition	mes, P.A. timore, mest,	Marylar Appr	nd 21231 eximate ral Between et and Death						
ner	resulting in deeth)	a	Due to (or a					Jease		
al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or a	uence of):						
Medical	thet initieted events resulting in death) Last	c	Due to (or a	s a consequ	uence of):			-		
cian		V.							1	
by Physician/M	Part II. Other algnificant conditions of	contributing to death	but not resulti	ng in the ur	nderlying cause give	ven in Pert I.		tobacco use cor Yes 2□ No	3 Probably	ause of death?
Completed b			H	ď.			perfe	an autopsy ormed?	24b. Were au available completi of death	topsy findings prior to on of cause ?
Comp								PECTION Yes XXNo	I Silver	2 No
Bec	25. Was case referred to medical axaminer?					26. Place of De	eth (Check only	one)		
10	TX Yes 2□ No	Hospitel: 1 Inpat	-	VOutpatien		4 LI Nursing	4343	idence 8 Oth		
Certification:	27. Manner of Death  14 Natural 5 Pending  2 Accident Investigation  3 Suicide 6 Could not be	e one Diese Att	lay Year)	Bb. Time of tnjury		ry et rk? Yes 2 □ No		how injury occurr		te Number
	4 Homicide determined	building, e	etc. (Specify)		eet, fectory, office	me date and also	City or To	wn, State)		
edical		miner: On the basis end menner s	of examinetion							cause(s)
M	29b. Signature and title of certifier	he You	e		29c. Licens	. C . M . E		29d. Date signed FEB.	26, 2	
	30. Name and address of person who  Margarita Kore  31. Date filed (Month, Dey, Year)	11 M.D.		1 Per	nn Stre	et, Bal	timore	, Maryl	and 21	201

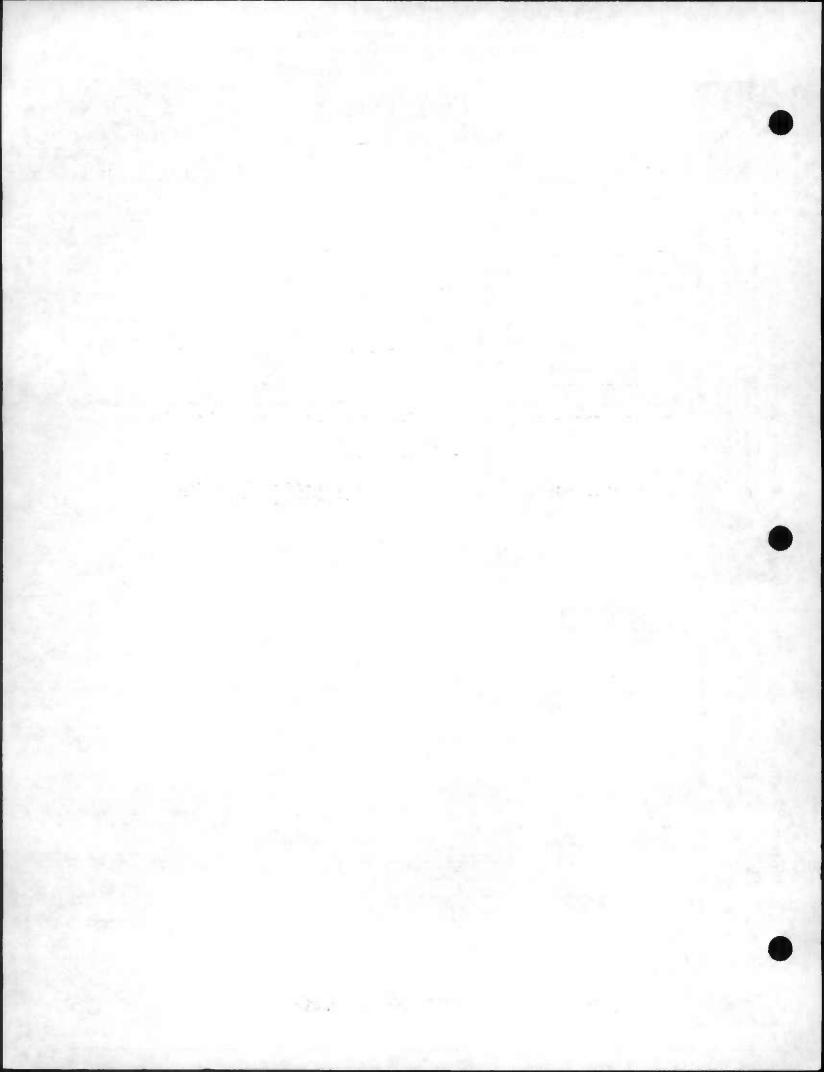
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 6396

				Certif	icate of l	Death		Reg. No.	00000
	Physician	1. Decedent's Name (First, Middle La	4 1 DA	NTON	16		2. Date of D	Day -	Year 7.7/()
N.	/Medical Examiner	4a Facility Name (It not institution, give		4-00	0 4	b. Sity, Town,	or Location of Dea	th 4c County	of Death 1 Death 1
4		ANNE FILLINI,	IEC WEOVIC	ACCII		MA	Mous	HANN	TE FRUMIBL
	Funeral Director	039-07-3343	Sex 7. Age (In yrs. 87		Under 1 Year onths Days	Hours N	Hrs. 8. Date of Bi (Month, D March 6		9. Birthplace (State or Foreign Country) I taly
Anna		Usual Residence of Decedent  10e. Stete 10b. County	10c. Cit	y, Town or Location	on		100		10d. Inside City Limits
Ma	ctor	MD Prince Ge	orge's	Bowie					1 🖾 Yes 2 🗆 No
4	r heme 23a or 28a-fa instrument be notified Funeral Director	10e. Street and Number	NE RESULT	1	Of. Zip Code			10g. Citizen of V	
4	era era	12715 Brunswick Lane	12. Wes Decedent Ever in U,	C 12 Was	2071		2 (Specify Ves or N		States a - American Indien,
21215-0020	Faminet must be notified at by Funeral Director	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1 🖺 Yes 2 🗎 No 41-4  If Yes, Give Yeer or Dates:	45	s, specify Cuba		? (Specify Yes or No ruerto Rican, etc.)	Rican, etc.)  Black, White, etc.  Specify: White	
5-0	ygiene. Ar Brandial Earl. Ar De Medical Earl. Completed by	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Decedent' (Give kind	's Usual Occup of work done o NOT use retired	ation during most of	working		siness/Industry
2121 White		Elementary/Secondary (0-12)	College (1-4or 5+)		nsit Work			New York	
	T 40 E	17. Father's Name (First, Middle, Last)		114	TISTE NOTE		Name (First, Middle		
/lar	end Mental Hygina marked other aumatic avant,	Vincent Dantone				No	unzia Murgu	lo	
2 2	Tie trans	19a. Informant's Name/Relationship ( Philomena Dantone –	**				or Aural Aoute Number wie, Marylai		State, Zip Code)
Baltimore,	ment of Heal ent: If Itam 2 ury or other	20a. Method of Disposition  1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Specify	Removal from State	Place of Disposition Place of Disposition Place of Disposition Place of Pla	ny or other plac	e)	Date 2/15/00	20c. Location - Waldorf	City or Town, State
Balt	Back in	21. Signature of Funeral Service Licer Michael L. Bigle		Rob		ans Fune	eral Home, Bowie. MD		
		23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that ceused the death						Approximate Interval Between
	hysician /Medical	Immediate Cause (Final disease or condition	CAA	ICER	¬ (	Coco	dw		Onset end Death  ( Lec
		resulting in death)	Due to (o	er as a consequen	ce of):				
x 68760,	physicien and s the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	b. Due to (a	r as a consequen	ce of):				
68760,	slcien e burie	that initiated events	C. Due to (o	r as e consequen	ce of):				
x 68	ding physicies as the bu	resulting in death) Last	d		30 31/1				
Boy	or un		u.					The Later	
0. 5	0 2 -	Pert II. Other significant conditions of	. 1	ulting in the under	tying cause give	en in Part I.		tobacco uae coi	atribute to the cause of death?
U	igned be detected by PI	CONCONFI	ry MKI	Eccy	1)(3	E1132		200	3 Probably 4 Direction
Records, P.O	ate has been signed begge 2 should b					3.1		s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
I Rec	page 2						10	Yes 20 No	1 ☐ Yes 2 ☐ No
/ita	certificate rector. pa	25. Was cese referred to medical examiner?					Death (Check only	one)	
of Vitai	S D L	1□ Yes 2□ Ne			3 DOA Oth	4 U NUISI	ng Home 5 Res		
	After fune	27. Manner of Death  15 Natural 5 Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury Work	yat k? Yes 2∐No		how injury occur	red
Division or Attending	at Director: After the in by the funeral Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e ogo Place of Laiver Athe	ome, farm, street, y)			28f. Location	(Street and Numb own, State)	er or Rural Route Number,
To the Hospital	within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	sysician: To the best of my kno niner: On the basis of examina and manner stated	wledge, death oct tion end/or investi	curred et the tin igation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time	cause(s) and ma , date and place,	nner as stated. and due to the cause(s)
d d	Within To the comple	25b. Signature and title of partitur	0 04/	1	29c. Licens	e number	0/	29d. Date signe	d (Month, Dey, Year)
		mall	1 Oll u	May	01	143	8	Feb 2	( 2000
		MIHAELJ	completed course of reath Men	1600	K (1) 6 E	24/1	15/6/	10 7	140/
	State	31. Date filed (Month EB 27)8	2000 32. Registração	D.	spou	Es			



#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEB 2000 25 /Medical y Name () pot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ens 0 If Under 1 Year 7. Age (In yra last birthday) **Funeral** Days 1 M 20 F Months Hours Yrs. Director Usuel Residence of Decedent 10a State 10h Counts 10c. City, Town or Location Baltimor 1 Ves 20 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Merital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 W No If Yes, Give Year or Detes: Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1□ Yes 20 No Specify Specify: U 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working) | Iffe. DO NOT use retired| , 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 1 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) tomema EVELYN 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be and Mental Zavall Informant's Neme/Reletionship (Type, Print) Method of Disposition Burial 2 Cremetion 3 Removel from State Ø Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardinated shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death ac or respiratory errest, Physician /Medical Immediate Cause (Final disease or condition resulting in death) Years Examiner Physician/Medical Examiner physicien and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indieted events The lew requires that the death certificate be executed Due to (or es a consequence of) 68760. that initieted events resulting in death) Last Due to (or as a consequence of): Box 997 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation deeth. 1 Yes 2 No 2 Accident after deeth Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi 29b. Signeture and title of cegtifier 29d. Dete signed (Month, Dey, Year) 2000 Marol D0054292

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**DHMH 16 Rev 6/95** 

State

Registrar

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1600 CRAIN HIGHWAY, SUITE 201, GLEN BURNIE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist/ar's Signature

JASSI

28

SUKHPAL 31. Date filed (Month, Day, Year) FEB 2

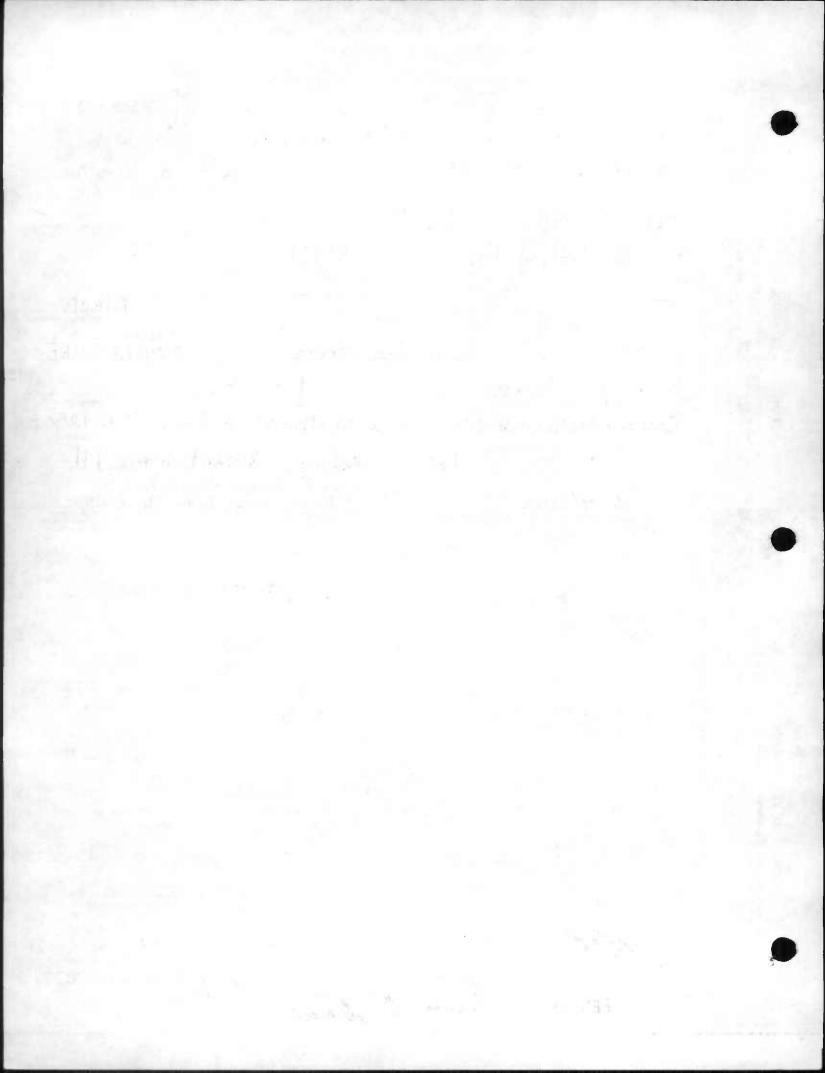
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

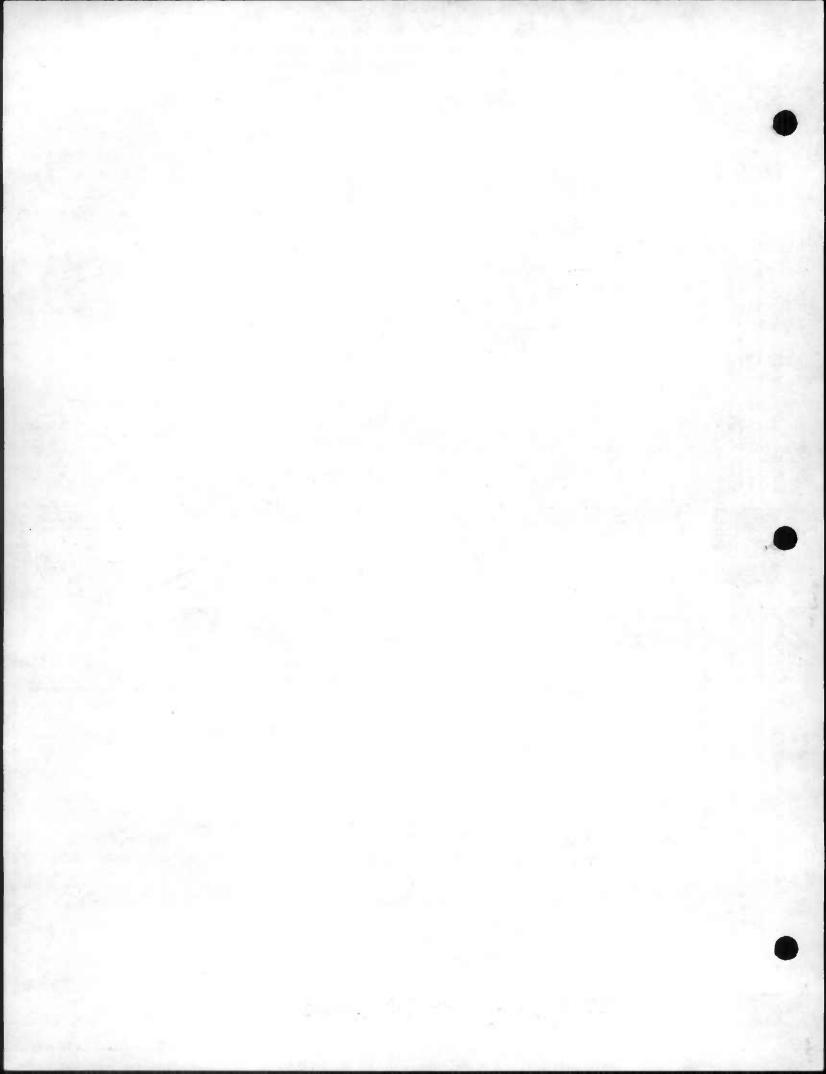
					Certificate	of Death	Reg. N	0.,	00000				
	Physicia	n	1. Decedent'a Name (First, Middle, La	L. Ellis		2	2. Date of Death	ay Ye					
	/Medic	al	4a Facility Name (If not institution, giv		Pike		EDPUCUTU	c. County of D	co 87 Upra				
	Examin	21	Pleasant Vie	0 1		mt Airy	(	Carro	011				
	Funeral		5. Social Security Number 6. S	DH ADE O.	t birthday) If Under 1 Months E	rear If Under 24 Hrs. 8 lays Hours Min.	. Date of Birth (Month, Day, Yea.	2 11	Birthplace (State or Foreign Country)				
L	Director		U73-U1-9792	45	113.		200	DIV	ingilla				
	how		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits				
21215-0020	Sa-f s	Director	Md. Larra	11 146	. Hiry		1.0		1 Yes 2 No				
	death with the Maryland ms 23a or 28a-f show count be notified at		10e. Street and Number	al Dka	10f. Kip Co	1771	10g. C	itizen of What	Country?				
		Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden	t of Hispanic Origin? (Speci Cuban, Mexican, Puerto Ri	fy Yes or No-		American Indian, White, etc.				
	ours a	þ	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 든		carr, etc.)	Specify:	black				
15-(	n 72 h	Completed	15. Decedent'a Ed (Specify only highest gra		6a. Decedent's Usual C (Give kind of work of life. DO NOT use	occupation None during most of working petired)		Kind of Buaine					
212	filed within Hygiena. ther than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Seams		1	19NUF	ACTURE				
	be filed tei Hygie d other event, p	Be	17. Fether's Name (First, Middle, Last,			18. Mother's Name (	First, Middle, Maide	n Sumame)					
Maryland	should be filed within and Mentel Hygiena.  marked other than umatic event, the Mentel than th	2	Washington  19a. Informant'a Name/Relationship (	) ones	10h Mailing Addrson /6	treet and Number or Rural	MING	or Tourn Sta	to Zin Coda)				
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ore,	of Heelth f Item 27 r other tr		20a. Method of Disposition	20b. Plac	e of Disposition (Name etery, crematory or other	of O	W. 1 - 1		or Town, State				
Baltimore,	Pe neur		4 Donation 5 Other (Specif		ro Cremo	tory 2.	29-2000 BC	Himor	e, Md.				
Bal	permit. Peg Department Important: I any Injury o		21. Signature of Funeral Service Licer	Pan	Jeff Mil	ter P.C. Funer	al Home &		10'es 21215				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I one cause on each line.	Do not enter the mode of	dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final	C	0.11.0				1.7 000				
	Examiner		disease or condition resulting in death)										
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	and al-tran	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):	0							
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89 X	ing p	S											
Box	atten d for u	Physician/	Part II. Other algnificant conditions of	contributing to death but not resulting	se niven in Part I	23b. Did tobacco use contribute to the cause of death?							
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Re	he law e has	Be Completed					1 ☐ Yes	2 13 No	of death?				
ital			25. Wes case referred to medical examiner?			26. Place of Deeth							
of V	£ £ =	ို	1 Yes 2 No		VOutpatient 3□ DOA		e 5 Residence		Specify)				
Ou	After fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	3b. Time of 28c Injury	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
Division	or Attending effer death. Director: After I in by the fune	tifica	3 Suicide 6 Could not b	O CO. Chan of taken	e, farm, street, factory, o								
ō	Ital or ral Dir lled in		401mmo	building, etc. (Specify)									
	Hosp 24 hou Fune staly fil	edical		ysician: To the best of my knowle niner: On the basis of examination and manner stated.									
		Me	29b. Signature apptilise of certifier	to to the story stated.	29c. L	icense number	29d. C	ate signed (A	signed (Month, Day, Year)				
	1		Meller	M.D.		126499	0	2-23-00					
- (	NO	1	30. Name and address of person who RONALD Mille	R MD # CI	ulwell Di	Rive MT.	Airy A	MARYL	and 21771				
	Stat Registra	_	31. Date filed (Month, PEB 2 8	2000 32. Registrar's Signature	B. 1	rall!	1						



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State of Maryland / Department of Health and Mental Hygiene 06399 Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death 235 Month Yaar **Physician** FEB. 2000 HUGH EAMES 17 /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Sinai Hospital N/A If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Under 1 Yeer 5. Sociel Security Number 6 Sax Birthplace (Stata or Foreign Country) **Funeral** Days Months 1⊠M 2□ F Director 353-09-6457 82 unknown Usuel Rastdence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Vas 2 No Director Baltimore N/A 258-1 10e Street and Number 10f. Zip Coda 10o. Citizen of What Country? itsms 23s or USA 21211 2095 Rockrose Ave Funeral 11 Marital Status Unknown 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amartcan Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yas 2 ☐ No If Yas, Giva "natural", or 1 ☐ Yas 2 ☒ No Specify: Specify 50 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: unknown white Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be 8 and Mental unknown unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ä Sinai Hospital 2401 E. Belvedere Ave Baltimore, MD 21215 mportant: If Itsm 27 altimore, 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Ramovet from Stata 4 ☑Donation 5 ☐ Other (Specify) in state 21. Signatura of Funaral Sarvice Licensee Ronald S. Wade 22. Nama and Addrass of Facility
State Anatomy Board 655 W. Baltimore Street **Director** Walle Tan Baltimore, MD 21201 Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neumonia da disaasa or conditior rasulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequance of): the for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? P.O. the the 1 ☐ Yes 2 ☑ No 3 3 Probably 4 Unknown 4) Zheimeis )omenta bengis d be del Records. A 24b. Ware autopsy findings available prior to Completed 24a. Wes en autopsy completion of cause of death? The 20 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 22 ER/Outpetient 3 ☐ DOA Certification: To this 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 27. Manner of Death 28d. Describe how tnjury occurred 28c. Injury at Work? After 5 Pending invastigation Neturel after death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Sutcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian Medical (Check only one) 29b. Signature and title of cartifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D23076 7-17-00 30. Nama end addrass of person who completed cause of death (ttem 23a) (Type, Print) 3730 Falls Ref Balt Med 21211 KICH ARD DIAMOND 32. Ragistar's Signatura State 2000 Registrar

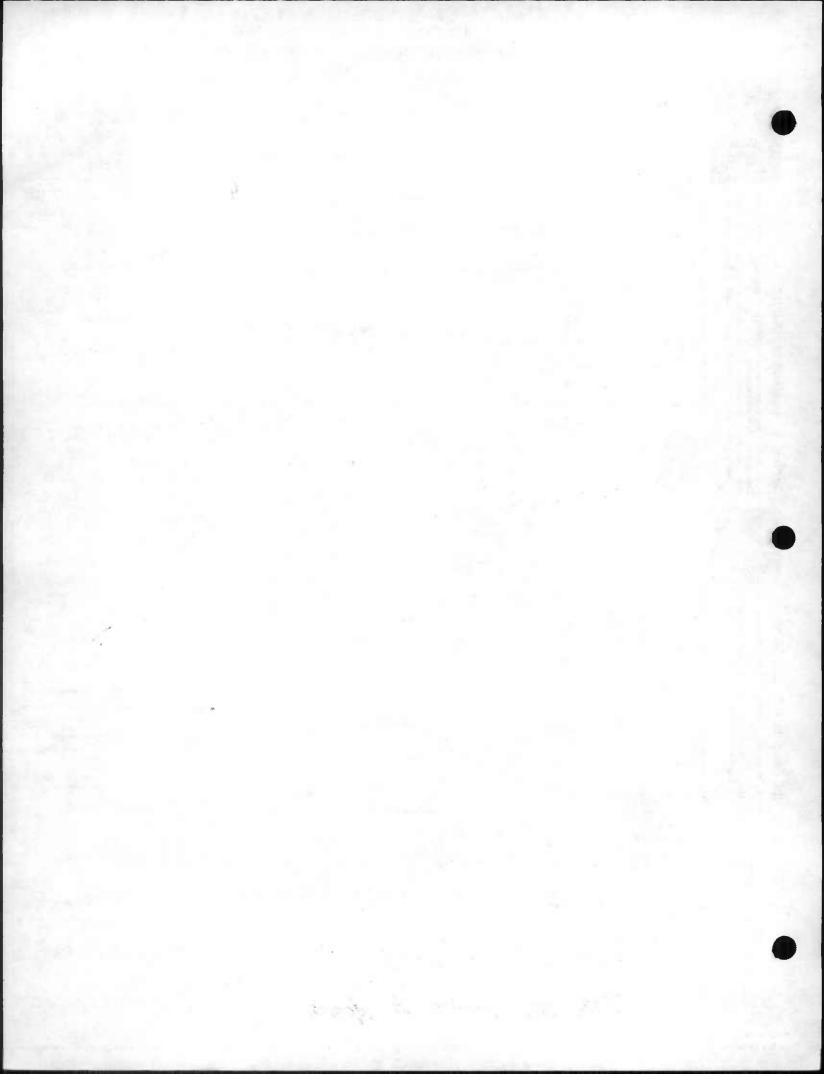


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State of Maryland / Department of Health and Mental Hygiene 00 06400.

			Ce	ertificat	e of	Death		Reg. No.	0 00	0400.		
	1. Decedent's Name (First, Middle, Last	)					2. Data of De	eath		3. Time of Death		
Physician /Medical	EDGAR J. FINK						FEBRUA	RY 24,	2000	2:00 PM		
Examiner	4a Facility Name (If not institution, give					4b. City, Town,	or Location of Deat	h 4c. Count	y of Death			
	5 Glenmont avenue					Glen Bu		Ann	e Aruno	del		
Funeral Director	5. Social Security Number 212.07.1733 6. Sax 84 Yrs. 84 Win. Days Hours Min. (Month, Day, Year) 5/5/1915								Birthplace (State or Foreign County)     Maryland			
pu a	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or I	Location					10d	I. Inside City Limits		
vith the Mary or 28a-f etc be notified	MD Anne Aru	ndel	Glen :	Burnie						1 ☐ Yes XX No		
after death with the Manylan or items 23e or 28e-f show refree must be notified at Funeral Director	6 Glenmont aven			10f. Zip Code 21061					10g. Citizen of What Country?  USA			
5-0020 72 hours after death with the Maryland natural; or thems 23e or 28e-f show size Exercites must be notified as ted by Funeral Director	11. Marilal Slatus  1 Never Married 2 Married  3. Marilad Universed	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	n U,S. 13	If Yes, spec		lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No erto Rican, etc.)	Bla	ce - American ack, White, etc by: white	3.		
	15. Decedent's Edu (Specify only highest gred		16a. Dec (Giv life.	edent's Usua ra kind of wor DO NOT us	al Occup rk done se retire	pation during most of v d)	working	16b. Kind of E	Business/Indus	stry		
212 d within giene. or than	10	College (1-40) 3+)	Mai	ntenan	ce -	- Painte	er	St. A	gnes Ho	ospital		
yland 2 ould be filed Mental Hygianked other rite event, in	17. Father's Name (First, Middle, Last)					18. Mother's N	leme (First, Middle	, Maiden Suma	me)			
re, Marylas s 1 and 2 should b f Health and Ments tem 27 is marked other treumatic o	19a. informant's Name/Relationship (Ty	rpe, Print)	19b. Ma	iling Address	(Street	and Number or	Rural Route Numb	er, City or Town	, State, Zip Co	ode)		
e, Ma 1 and 2: Health as Pm 27 is wher tree	Wayne Fink - Son		1019	Bell	Avei	nue. Gle	en Burnie	. MD 21	060			
0 85= P	20a. Method of Disposition 1 ☐ Cramation 3 ☐ F	emoval from State	cemetery, cr	position (Namemetory or o	ne of ther ple	ce)	Date	20c. Location	- City or Town	ı, State		
Baltir Semit. Pa Separtment mportant: ony injury ance.	4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Dainy		leadowr:			Park oss of Facility	2/28/00					
Depa Depa Impo	Kelly Gregory						FINK FU SW, Glen					
Physician /Medical Examiner	23a. Part . Entar the disease, or complished k, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	Metabat		1)1 (ell	0		erto2	1	In	iterval Between Inset and Death		
68760, tificate be executed to physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.								1			
T. 2 2 4												
death death es atter ed for u	Part II. Other algnificant conditions con	tributing to death but not	death but not resulting In the underlying cause given in Part I.					23b. Did tobacco usa contribute to the cause of death?				
P.O. hat the deby the detach.							XX	Yes 2 No	3 Probal	bly 4 Unknown		
aw requires to the second as t								an eutopsy omed?	availe	e eutopsy lindings able prior to plation of cause ath?		
The law ate has page 2	Miles make a control of the						10	Yes XX No	101	Yes 2□ No		
of VItal Ri Physician: The I this certificate he al director, page: To Be Com	25. Was case referred to medical examiner?						Deeth (Check only		-16 1	1.		
Of VIta Physician: this certific ral director,	1 ☐ Yes 2 No					4 LI NUISIR	g Home 5 ☐ Res		xxgirlfriends resi			
Vision of Attending Por death. ector: After the type the funeral iffication:	27. Manner of Death  12 Natural 5 Pending  2 Accident Investigation	28a. Date of injury (Month, Day Year	28b. Time Injury	b. Time of 28 Injury M		ryat rk? Yes 2 □ No	28d. Describe	scribe how injury occurred				
	3 Suicide 6 Could not be determined	building, etc. (Specify)						28l. Location (Street end Number or Rural Route Number, City or Town, Stete)				
To the Hospital or within 24 hours after To the Funerel Dir completely filled in Medical Cert	29a. Certifiar (Check only one) XX Certifying Phys	nician: To the best of my liner: On the basis of examend menner steted.	knowledge, dee ination and/or i	eth occurred a nvestigation,	at the tir , in my c	me, date end ple opinion, deeth o	ace, end due to the ocurred at the time,	cause(s) and m date end place	nanner as state, and due to the	ed. ne cause(s)		
To the comp	29b. Signature and title of certifier		1	290	. Licens	se number		29d. Date sign	ed (Month, Da	ly, Year)		
	Dund	no	1		3155	51		Februa	ry 28,	2000		
10	30. Name end address of person who co											
State	Russell R. DeLuca	MD 1600		h Hwy	1	ste. 602	2, Glen B	urnie,	MD 2106	).		

DHMH 16 Rav 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 00 AM TREDDIE TELDER 02--00 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE 3403 DRIVE KANDALLSTOWN MERIF If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthptece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min 10 M 20 F Months Days Hours Yrs. 619-52-1388 Director Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f ahov notified at 1 Yes 2 No MO BALTIMORE RANDALLSTOWN Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 the Medical Examiner must be 238 DRIVE 21244 3403 MERLE USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: Nema Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 "natural", or 1□Yes 2□No Specify. BLACK by 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) Cottege (1-4or 5+) FORK PERATOR COKE COLA OMPANY 12 TH GRADE NA ith and Mental Hygier 27 is marked other to r traumatic avent, to 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental in the marked or WILLIE FELDER LARK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) BROTHER KANDALISTOWN MERLE MD. 21244 MOYO TELDER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 2.29-00 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 21. Signature of Funeral-Service Licensee 22. Nama and Addrass of Facility SERVICE VAUGHN C. GREENE FUNERAL au 5151 BALTO. NATE PIKE BALTO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in deeth) 2 /2 months /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentiatly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or injury and ata has been signed by the attanding physician page 2 should be detached for use as the buna 68760 that Initiated evants resulting In death) Last Dua to (or as a consequence of): Box ( Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Division of Vital Records. à 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No After this certificate Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Appliation Attending Physical Start death.

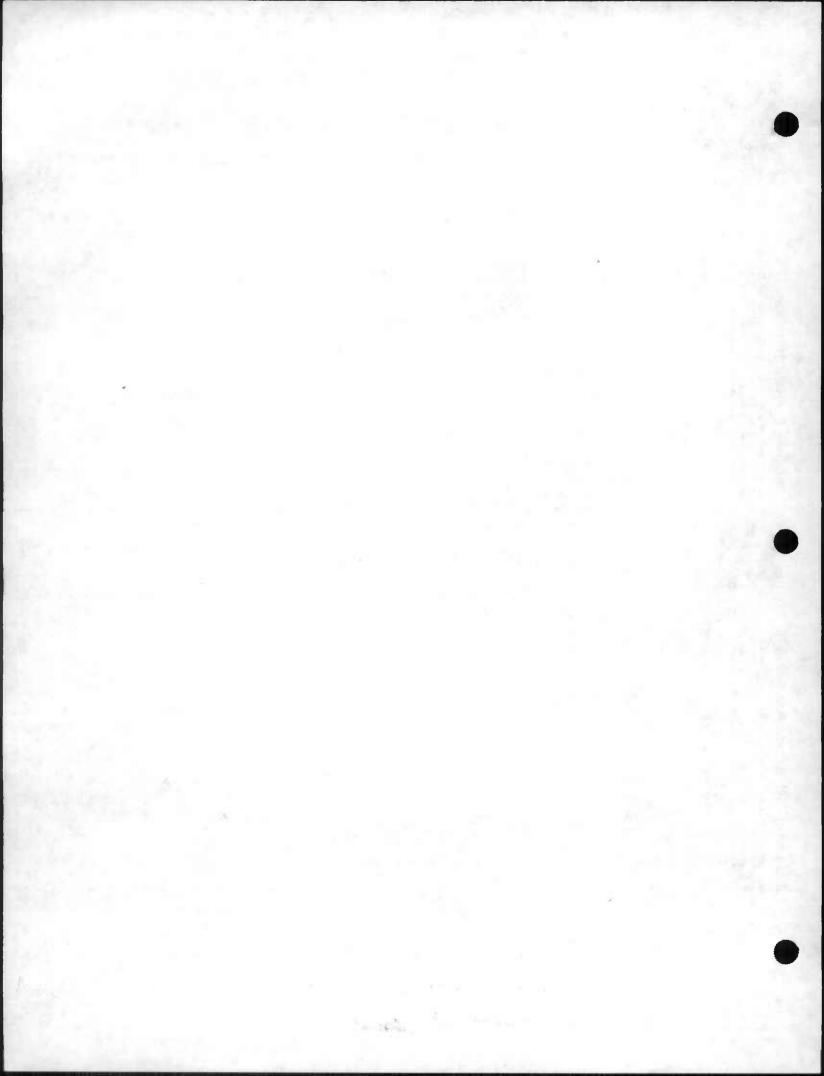
Moral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Neturat 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be 28a. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 15 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. Licensa number eted cause of death (Item 23a) (Type, Print) Hospital, WON. Wolfe St., Baltimare, MD, 2489 G. Fra Tim, MO, PhD. Johns 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

FEB 2 8 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dav Month Year GENEVIEVE CATHERINE FRY February 24, 2000 4:16 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5707 Fenwick Avenue Baltimore City N/A If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months Days 1□M 2₩F 86 212-18-2308 Sept.17.1913 Maryland Usual Rasidance of Decedant 10b. County 10a. Stata 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore City 1 Vas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5707 Fenwick Avenue 21239 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Giva 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) 6 yr's Tailor Clothing 17. Fathar's Nama (First, Middle, Last) 18 Mother's Nama (First Middle Meiden Sumeme) Frank Magri Rosalie Crimy. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Mrs. Mary Roppelt - Niece 5707 Fenwick Avenue Baltimore, MD 20b. Place of Disposition (Neme of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Holy Redeemer 4 ☐ Donation 5 ☐ Othar (Specify) 2/28/00 Baltimore, MD 21. Signature of Funaral Service Licensee Paul L. Hartsock, Jr. 22. Nama and Addrass of Facility Baltimore, Maryland 21214 Inc. 5305 Harford Rd. Leonard J. Ruck, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrast, shock, or heart failure. List only one ceuse on each lina. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in daath) Atherosclerote Cardibiascular Disease Dua to (or as a consequence of): Ulars Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Causa (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of) - ongestive Heart Faylur Due to (or as a consequence of) Myelodysplastic Syndrome Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown neumonia 24a. Was an autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ahow

r than "natural", or home 23e or 28e-f ahor the Medical Examiner must be notified at

Funeral Director

Be Completed by

with the Manyland

filed within 72 hours after

nd Mental Hygiene. marked other than

permit. Pages 1 end 2 should be filk Department of Health and Mental Hy important: If item 27 Ia marked oth any Injury or other traumatic event

Baitimore, Maryland 21215-0020

sician and burial-transit The lew requires that the death certificate be execu the USB 85 signed by the atte or Attending Physician: this funeral e Hospital or Attending n 24 hours after death. He Funerel Director: Aft

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner g Be Completed Medical Certification: To lilled in by

24b. Wara autopsy findings availabla prior fo complation of causa of death? 2 No 1 Yas 2 No 1 ☐ Yas 25. Wes case rafarred to medical examiner? 26. Place of Death (Check only ona) 200 No Hospifal: Other: 4 Nursing Homa Rasidence 6 Other (Specify) 1 Yas 1 Inpatiant 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Yas 2 No 2 Accident 8 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifia

Md.)

D 48039

February 25, 2000



State Registrar

completely

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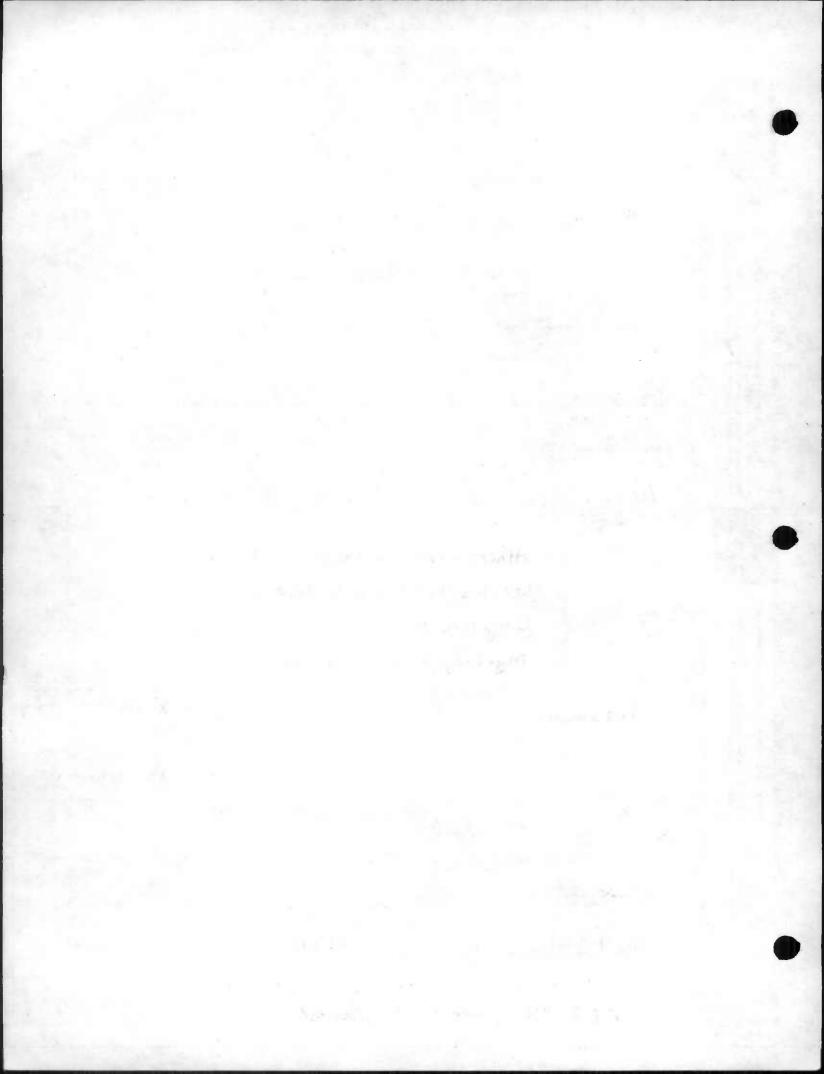
**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) FEB 2 8 2000

nouse 30. Nama and addrass of person who complated cause of death (Item 23e) (Type, Print)



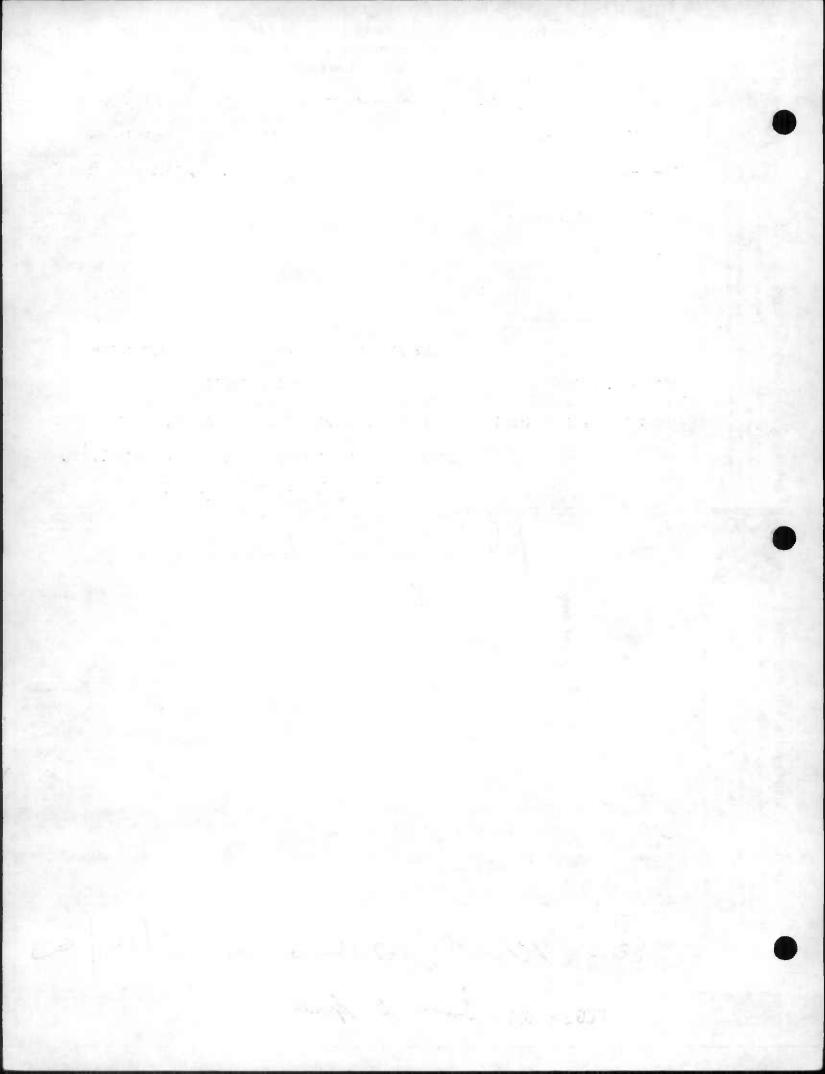
**ORIGINAL** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** February 2000 Dorothy Georgieff 6:00PM 24 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6723 Oak Ave. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Min. Hours 1 M 2 XF Yrs. 76 Mar. 29, 219-18-1772 1923 Maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits The 23s or 28s-f show 1 Yes 2 No Directo Maryland Baltimore Dundalk 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6723 Oak Avenue 21222 United States Funerai Herns ? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status Pages 1 and 2 should be filled within 72 hours after of nent of Health and Mental hygiene.
Int! If Item 27 is merked other than "natural", or item ury or other traumatic event, the Medical Exercities. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Manager Retail Sales 12 years Baltimore, Maryland 17. Father's Name (First, Middle, Last. 18 Mothar's Nama (First, Middle, Maiden Surname) Be Bernice Sterling William F. Smith 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 9007 Throgmorton Road Baltimore, Maryland 21234 Randolph Georgieff (Son) 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Dete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: H any Injury o once. Baltimore National Cemetery 2/28/2000 Balto., Md. 21. Signature of Funeral Service Licen-22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, MD 21222
Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the buria Box 68760, Physiclan/Medicai Due to (or as a consequence of): 88 for use signed by the a 23b. Did tobacco use contributs to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Wera autopsy findings svailable prior to should Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No certificate Physician: 89 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division or Attending 1 Natural 5 Pending investigation s after death. 1 | Yes 2 | No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicida 24 hours Hospital 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to tha causa(s) end menner as stated. completely 2 Medicat Examiner: On the basis of examiner and manner stated. (Check only one) mination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day 31. Date filed (Month, Day, Year, 32. Registrary State FEB 2 Registrar

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Martha Marie Grav 2:20pm 24 FEB 2000 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Ivy Hall Geriatric Center Essex Baltimore If Under 24 Hrs. 8. Data of Birth (Month, pay, Year) JULY 29, 1926 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Days 73 Yes Pennsylvania 174-24-4555 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yas 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Windlass Drive Rm#503-A 21220 IISA Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married White 1 Yes 2 No Specify: Specify: 3 Widowed 4 NDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) 12 College (1-4or 5+) Tavern/Restaurant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Benoni Emma Gelmini 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21221 Linda Wagner/daughter 1621 Howard Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/25/00 Metro Crematory, Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licenses Cremation Society of Maryland, Inc. McDonald McDonald Dawn Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Parkingais disease Advanced Immediata Causa (Final un known diseasa or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

Physician/Medical Examiner • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760. Records. by Completed Division of Vitai Be Certification: To 5

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28s-f ahow digs! Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any Injury or other traumedc event, the Med Brice.

**Physician** 

/Medical

Examiner

death

72 hours after

altimore, Maryland 21215-0020

Director

Funeral

Completed

25. Was casa referred to medical 1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accident 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Cartifian Medical

15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifiar

Mosso MD

38754

02-25-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASBAM. 406. BASTERN

WASBRM.

BLUD.

MD-21221

Registrar

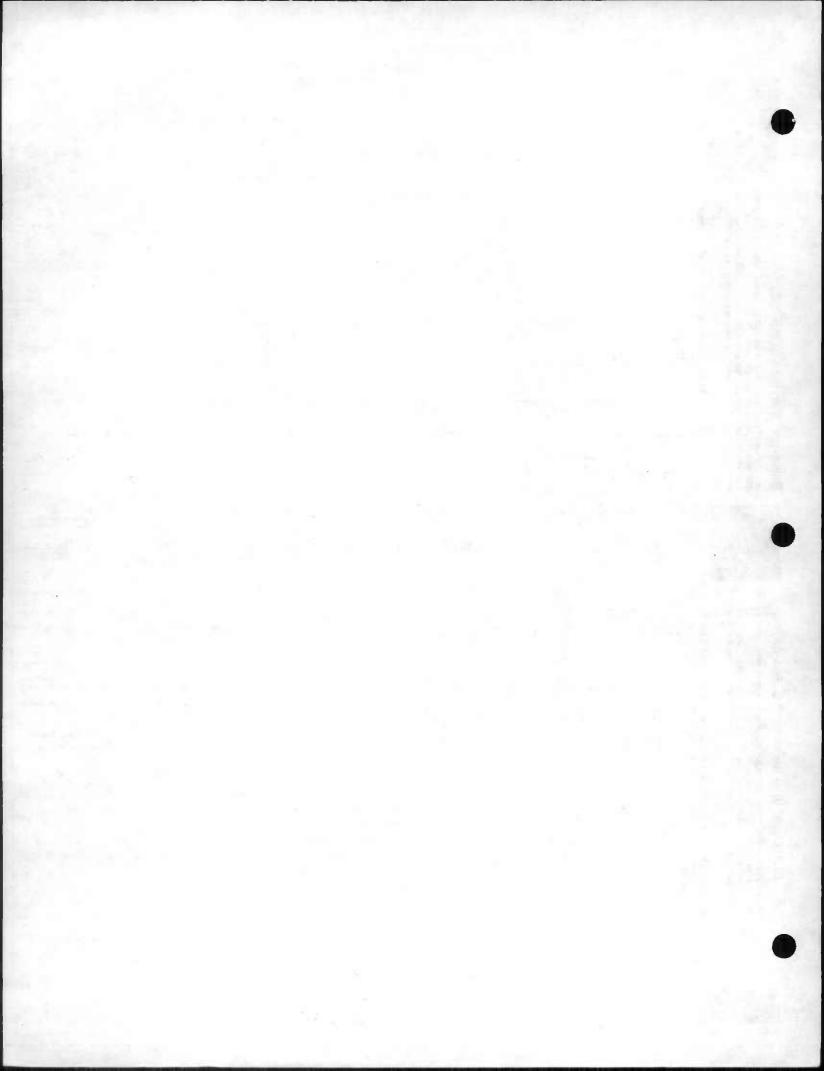
within 2

**DHMH 16 Rev 6/95** 

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31. Date filed (Month, Day, Year) .

32. Regittgar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Carl D. Hubert FEBRUARY 24 20:15 PM 2000 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Deeth Union Memorial Hospital Baltimore If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours MM 20F Yrs. 219-03-4492 84 Feb 26, 1915 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Parkville 10g. Citizen of Whet Country? 10e. Street and Number 10f Zin Code 21234 8316 Nunley Drive , Apartment C U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Never Married 2 ☐ Married NOXYes 2 No If Yes, Give WWII Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Electrician U.S. Government 17. Fethar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Charles Hubert May Gootee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Richard B. Grubb (stepbrother) 8316 Nunley Drive, Apt. C, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Gardens of Faith 2/28/2000 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Nama and Address of Facility Bruzdzinski Funeral Hoem, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart tellure. List only one ceusa on aech line. Pneumonia Immediate Cause (Final disease or condition resulting in death) chronic obstructive pulmonary disease Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or thjury that initiated events resulting in death) Lest Due to (or es a consequence of): years Hypertynsion Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Depression prostatic hyposplasia 24b. Wara autopsy tindings aveilable prior to 24a. Was an eutopsy completion of cause of death? 2 No 1 ☐ Yes 20XNo 1 Yes 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

lith end Mental Hygiene. 27 la marked other than "r r traumatic avent, me Wed

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Director

Funeral

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21215-0020

Baitimore, Maryland

P.O. Box 68760,

Records,

Division of Vital or Attanding Physician:

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Registrar

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Hospital or Attandi 24 hours after deeth Funeral Director:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural

5 Panding investigation 1 Yes 2 No 2 Accidant 3 Suicide

6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Ptece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29e. Cartifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

14. humana 30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

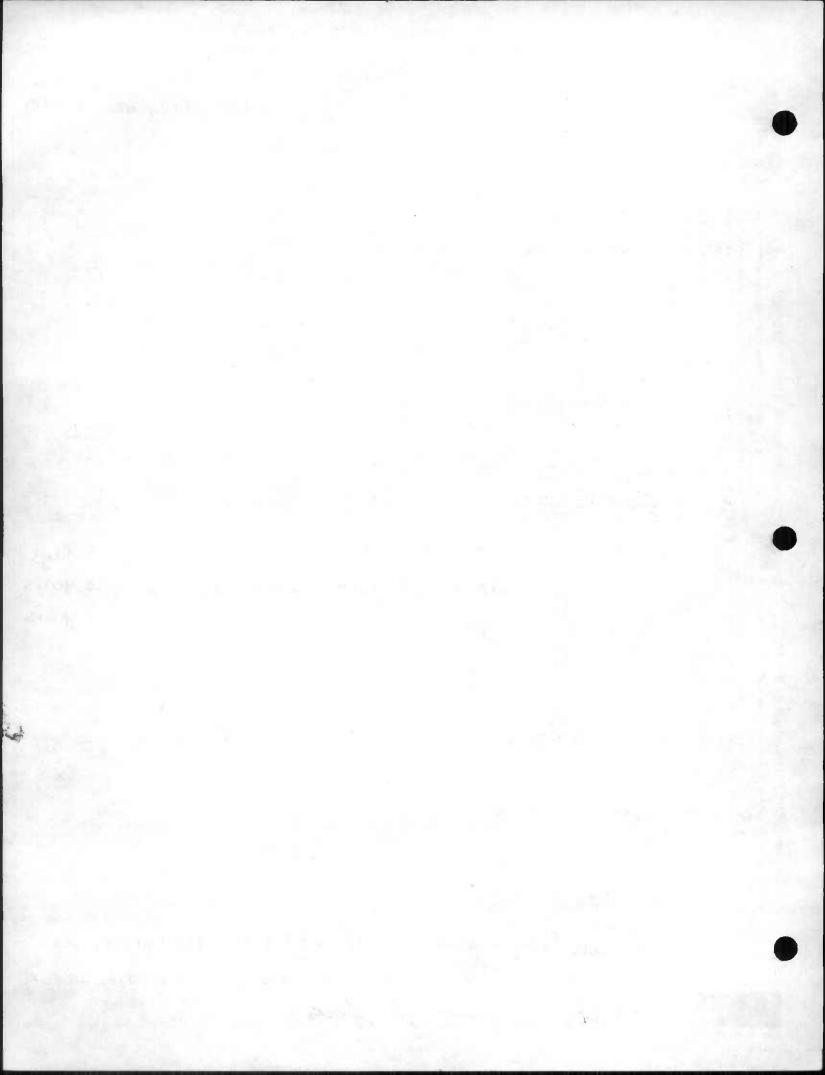
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LOVEEN J PUTHUMANA, DEPARTMENT OF MEDIUNE UNION MEMORIAL HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrer's Signature

**DHMH 16 Ray 6/95** 



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death FEBRUARY 26, **Physician** Robert 2000 8:30 PM 7. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 F 220-09-8325 Maryland 80 Director Jul 20, Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Baltimore
100. Street and Number Timonium Directo 10f. Zip Code 10g. Citizen of What Country? ted States

14. Race - American Indian, 321 Gailridge Road 21093 United death 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑ Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Bleck, Whita, etc. 72 hours after 1 Never Married 2 Married 21215-0020 1□ Yes 2 No MYes, Give Year or Dates: WWII Specify: Specity: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electronics Engineer years years 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mothar's Nema (First, Middle, Maiden Surnama) Be Mazie Jenkins William B. Hal 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 Gailridge Rd. Timonium, MD 21093

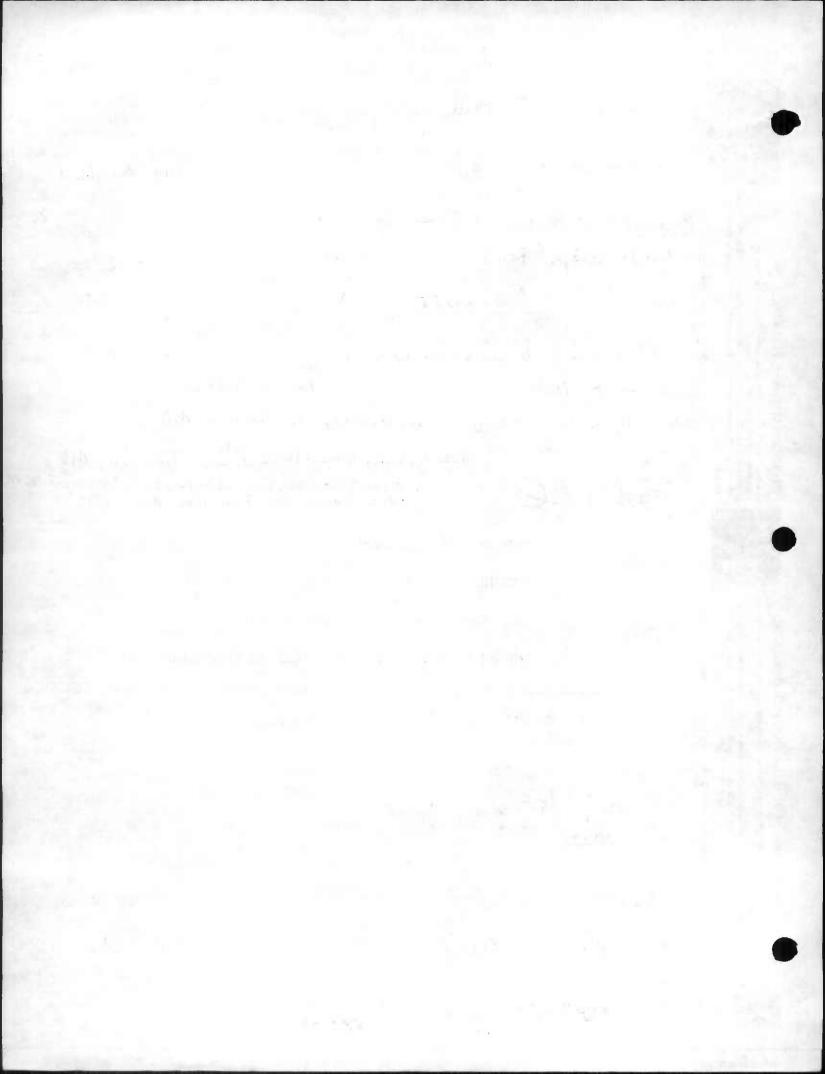
20b. Place of Disposition (Nama of cematary, crematory or other place)

20c. Location - City or To Elbworth R. Hall - 50n 20a. Mathod of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from Stata Dulaney Kalley Memorial Godns 29, 2000 4 Donation 5 Other (Specify) 32. Nama and Addrass of Facility Funeral Services of Bulancy Valla P.A. 21. Signature of Fundial Service Licens Padonia Rd. Timonium 200 E. 21093 23a Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** ASPIRATION PNEUMONIA /Medical Immediata Cause (Finel diseasa or condition rasulting in death) Examiner Due to (or as a consequence of): PROGRESSIVE MULTI LEUKOENCEPHALOPATHY Examiner sician and burial-transit be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): LOW GRADE LYMPHOMA STAGE III-A Box 68760, Physician/Medical The law requires that the death certificate Due to (or as a consequence of) INFARCTION OF THE LEFT DEEP CEREBELLAR HEMI nse nse Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BILATERAL MAXILLARY SINUSITIS þ 24b. Were autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manger of Death 28b. Time of 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? or Attending 5 Pending investigation 1 Matural s after death.

I Director: After din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and 1859 of continuo 29c. Licensa number D25886 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LILIA CEBALLOS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Flug star's Signatura FEB 2 8 2000 State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06407 Certificate of Death Rea. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 1050 Month Day Year 4b. City, Town, or Location of Death 4c. County of Death Wiley S, Hanley 4a Facility Nama (If not Institution, give street and number) e @ Mercy 7. Aga (In yrs. last birthday) Baltimore Stella Maris Hospice @ NA If Linder 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F Yrs. 69 225-34-4357 VA 04 - 10 - 30Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yas 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2705 East Chase Street 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐No If Yas, Give 1 Nevar Married 20 Married 1 Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 8th Grade Brick Maker General Refactory 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Lewis Α. HAnley Ella Mae Washington 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) 2705 East Chase Street Baltimore, Maryland Data 20c. Location - City or Town, State Julia Hanley 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 02-26-2000 Baltimore, MD 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licenses Baltimore, Maryland 21202 ales les WM.C.March FH 1101 E. North Avenue 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediata Causa (Final diseasa or condition rasulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 □ Yas 25. Was case referred to medical examinar? MARIS AT MERC 26. Place of Deeth (Check only one) TE//A Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 1 Netural 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No investigetion 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Plece of Injury - At homa, larm, street, lactory, office building, etc. (Specify) 4 ☐ Homicida 29e. Cartifian -1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. (Check only one)

Examine be assecuted Box 68760. P.O. Records. The law Division of Vitai Attanding 6 Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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**Physician** /Medical

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To the Funeral Director: A completely filled in by the fi

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Baltimore, Maryland 21215-0020

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Medical Certification: To

**DHMH 16 Rev 6/95** 

State Registrar

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29b. Signature and title of certifie

DAVID

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

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2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

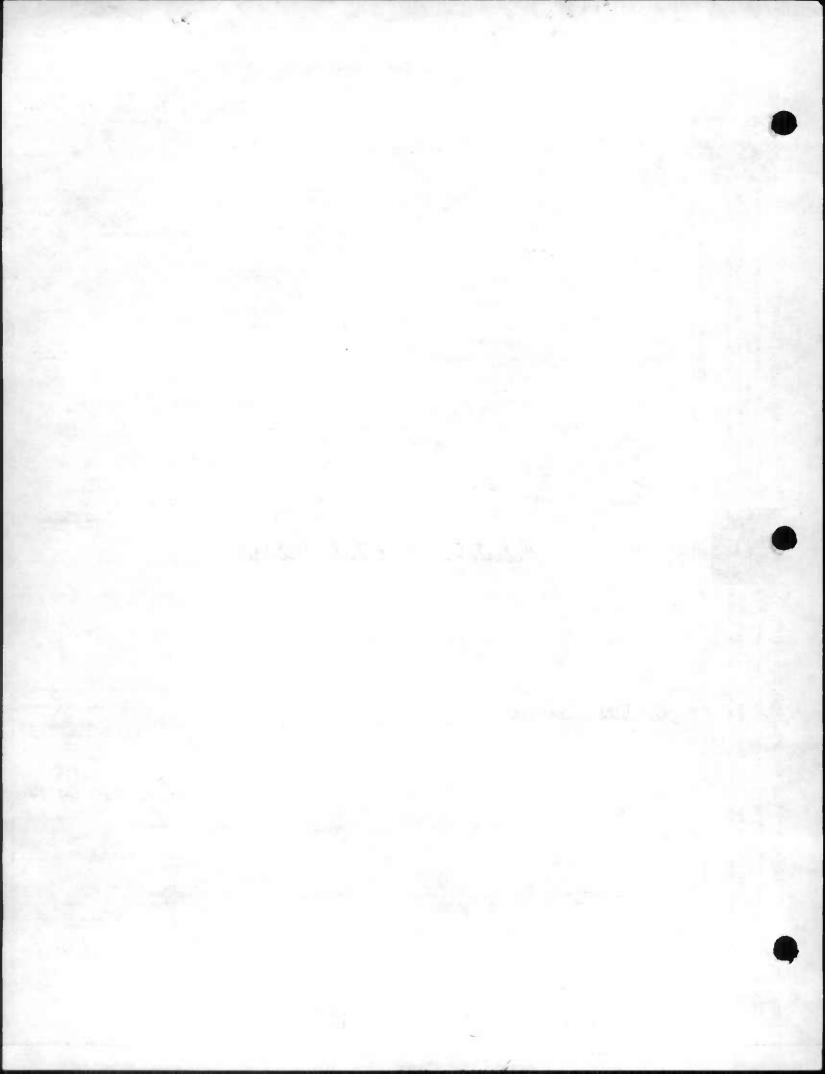
29c. License number

29d. Data signed (Month, Day, Year)

Md

BAHIMORE

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death HOULD 2:05 AM **Physician** FLESTE February 26,2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Baltimore Rehabilatation and Extended Care Baltimore If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth Month Day Year) FB 19, 1912 9. Birthplaca (Stata or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) 10 M XOF Days Hours Min Maryland Yrs 214-12-1875 Usual Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yes 2√ No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 21244 1914 Brook Dale Road Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas 2 □ No WW I I If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian Black, White, atc. 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: p White 3☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grade complated) Elamantary/Secondary (0-12) Sollaga (1-4or 5+) Registered Nurse Private Duty 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middla, Last) 8 Matilida Kopp Andrew Jackson, Jr. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Harvey P. Jackson/brother 4725 Luerssen Ave. Baltimore, MD21206 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Framation 3 ☐ Ramoval from State 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 2/28/00 Baltimore, MD 21. Signature of Surreral Survive Uniques

Thomas Gregor 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Batwean Onsat and Death Immediata Causa (Final diseasa or condition rasulting in death) Coronary arter 4 years Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consaguance of): Physician/Medical Due to (or as a consequance of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to 24a. Was an autopsy Completed completion of causa of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa refarred to medical examiner? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yas 2 No 10 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28h Time of Certification: 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No Invastigation 2 Accident 6 Could not be datarminad 3 ☐ Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and titla of certifie 20032548

Registrar

L. COLVIN

32. Resistrat's Signature

February 26,2000

of person who complated cause of daath (Itam 23a) (Type, Print) 10 North Greene Street L. Co LUIN Baltimore Maryland

DHMH 16 Rev 6/95

**Funeral** 

Director

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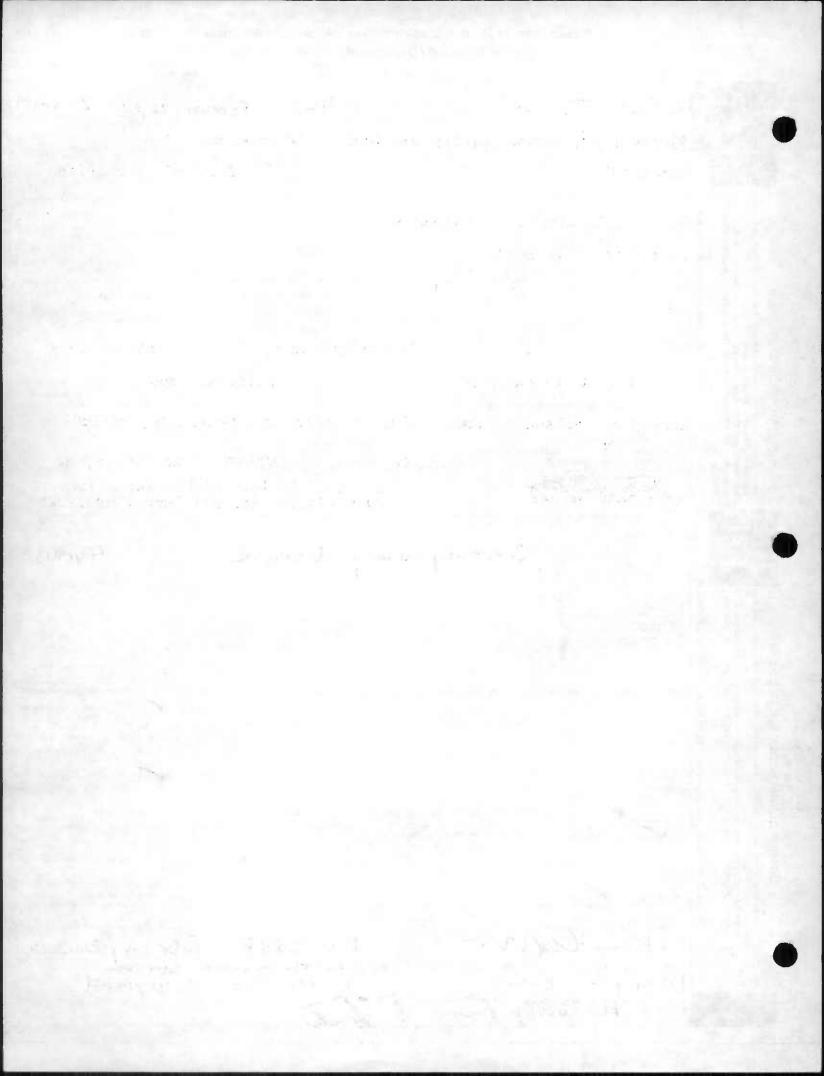
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Records, P.O.

Division of Vital

Baltimore, Maryland 21215-0020

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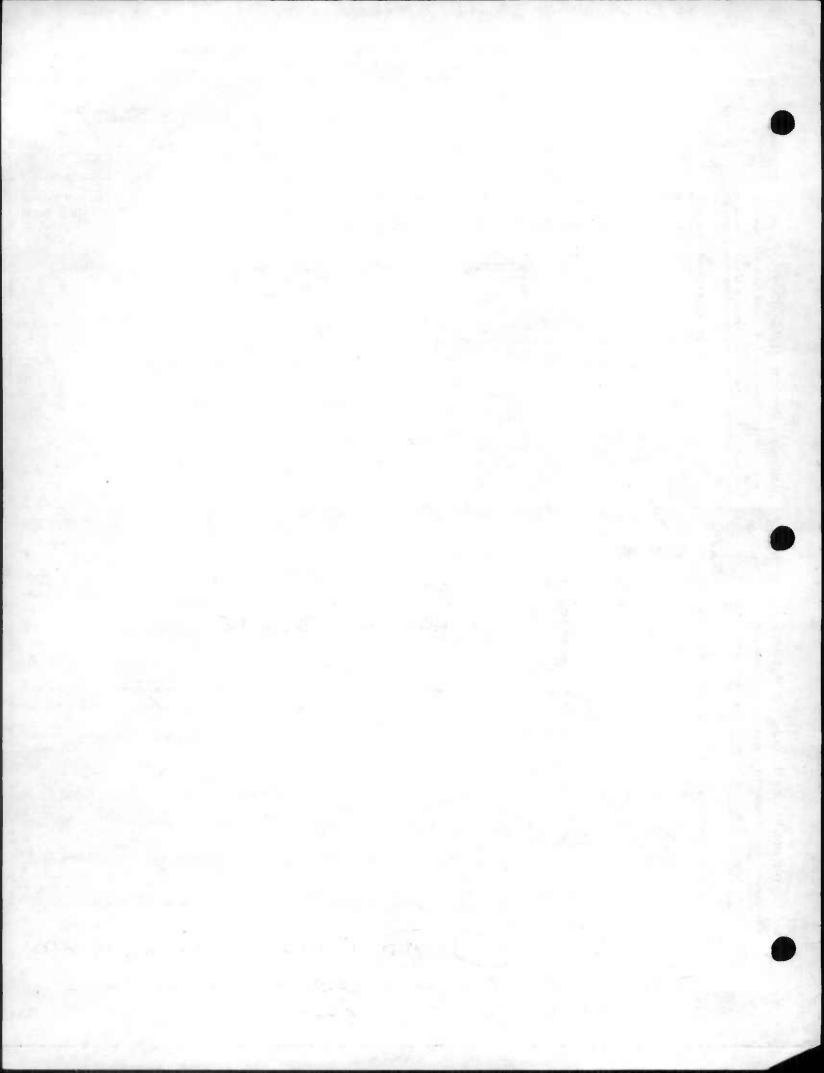
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dev Month **Physician** SHEILA HOLM 3000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death **Examiner** nder 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 3, 1958 MEDICAL CENTE

7. Age (In yrs. last birthday) | H UNIVERSITYOF MARYLAND MEDICAL H Under 1 Year Months Days MARYLAND BALTIMORECE If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** Hours 10 M 20 F Director 41 083-54-3930 Usual Residence of Decedent the Marylend 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location iral, or items 23s or 28s-f show Examiner must be notified at 1 Ves 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 2625 Boone Street USA death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or Not Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forcas? Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give △ Yeer or Detes: Black 1 Yes 2 No Specify: 21215-0020 "natural", or by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Int: If item 27 is marked other than ury or other treumstic event, or a Mark College (1-4or 5+) Hospital Nursing Assistant Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Doris Isroam Vincent Holm 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shalarmanda Fuller/daughter 2625 Boone Street Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State permit. Page Department of Important: If eny injury or page. Metro Crematory, Inc. 2/24/00 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) PNEUMONIA Examiner Due to (or as a consequence of): Examiner AIDS physicien and s the buriel-transit that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, HODGKINS DISEASE Physician/Medical Due to (or es e consequence of): 98 usa 0 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Punknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2PLNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27 Menmer of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident • Funeral Director: A Florath Office of Funeral Director: A selective filled in by the I 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide Hospital edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completaly fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end the of pentil 29c. License number 2000 18 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) ST. BALTIMORE MD BENSEN M. 22 S. GREEN DEBRA

State Registrar

31. Date filed (Month, Day, Year) FEB 2 8 2000 32. Registrar's Signeture

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** -eb/nn/y 26, 2000 4c. County of Death 0 06:10 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) Examiner BAI In S 4 If Under 10 mure INA 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 69 215-28-1554 June 26, Maryland Director Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Directo Maryland Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? F is marked other than "natural", or herra 23s or traumatic event, the Medical Examiner must be o 10809 Davis Avenue 21163 United States Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1X Yes 2 □ No If Yas, Give Year or Dates: Korea 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 Never Marriad 2 Married 1 Yas 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced atient Known As Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Hygiana. College (1-4or 5+) Elementery/Secondery (0-12) Manager Economic Analysis AT&T/Bell Atlantic 12th Grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) Be Mental marked James Emmett Hiltz Mildred Albert A Bug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Item 27 Mrs. Dorothy Hiltz - Wife 10809 Davis Avenue; Woodstock, Maryland 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of P Important: If its Pages 1 XBurial 2 Cremation 3 Ramoval from Stata 8 Woodstock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. Alphonsus Cemetery2/29/2000 22. Name and Address of Facility 21. Signature of Funeral Sarvica Licensee MO0869 Loring Byers Funeral Directors, Inc. 23a. Part 1. Solef the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximete

Approximete Approximete Interval Between Onset and Death **Physician** (ardiv myopothy /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequenca of) Box 68760. certificate be Physician/Medical Due to (or as a consequence of) 88 9SD Pol signed by the a 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Junknown ð 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of causa of death? has pege 2 1□Yes 20No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1□ Yes 2 No Nnpatient 2□ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation Natural after death. Director: Aft 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certiliar AS 2402321-1214 2436 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sinal Thana COY Mospita

32. Registrar Signature

Denew

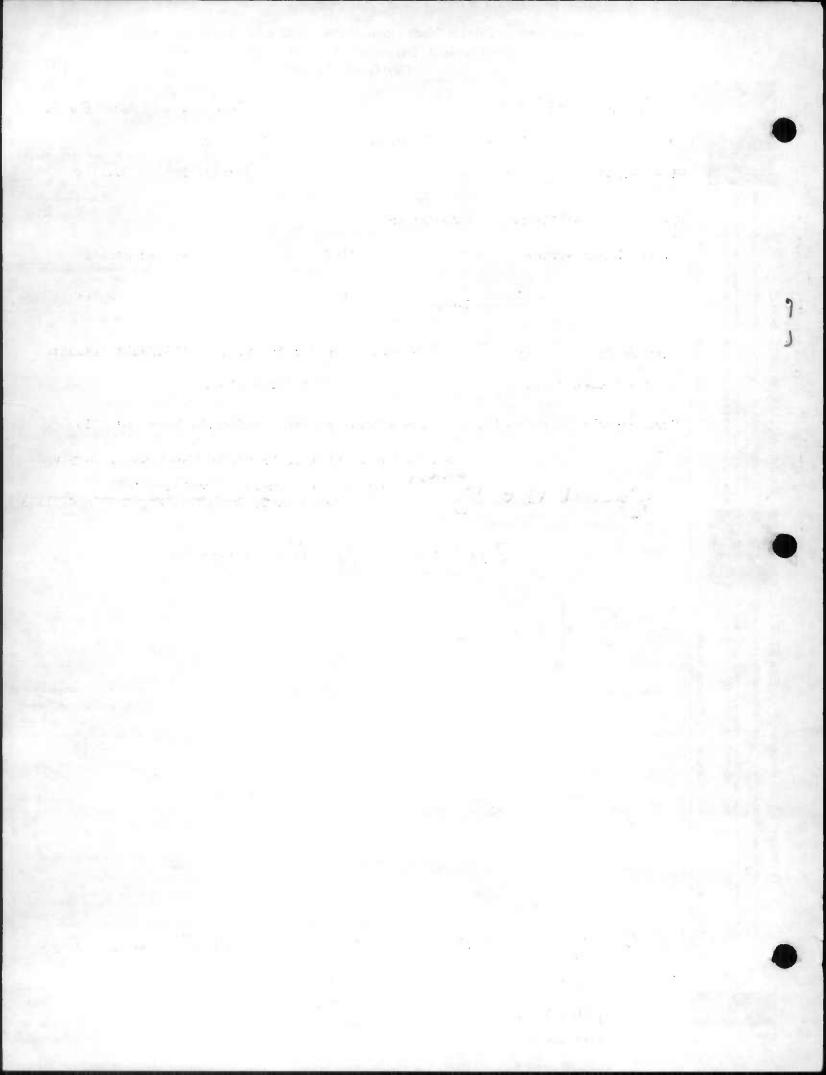
DHMH 16 Ray 6/95

State

Registrar

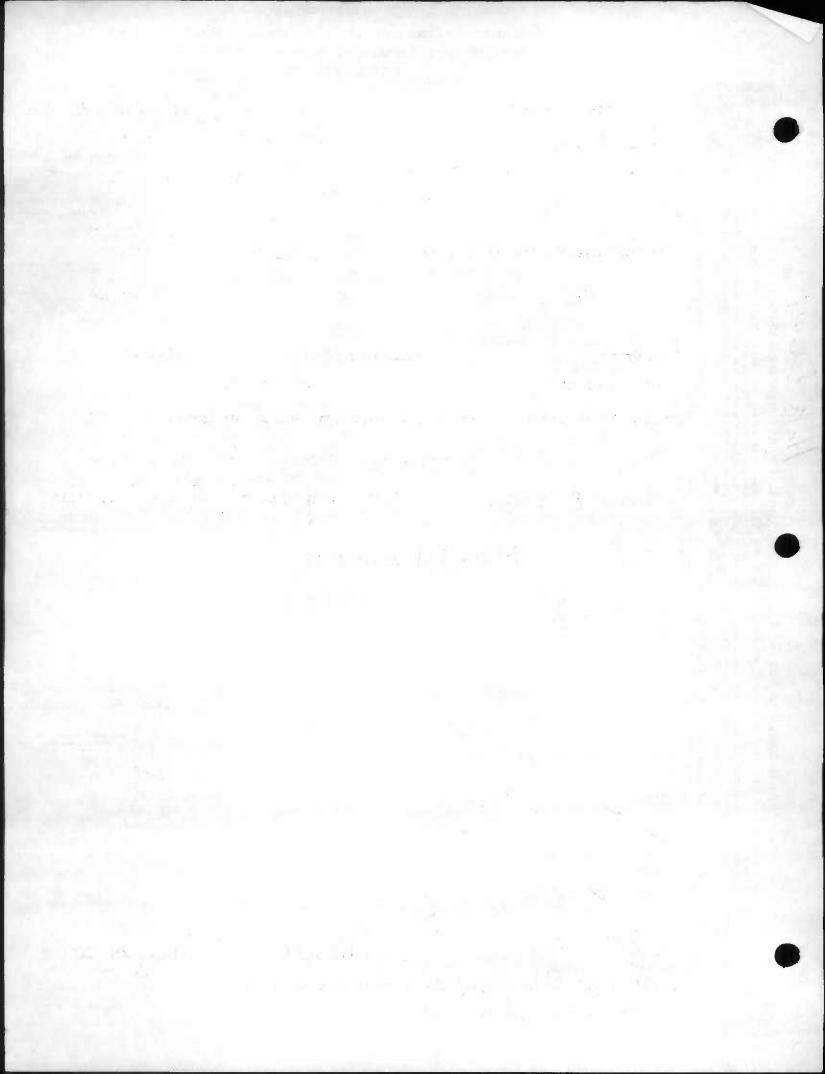
31. Date filed (Month, Dey, Year)

FEB28



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Yaa **Physician** Dorothy G. Hicks 2000 Physic /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 10 M 200 217-38-1649 60 Yrs Director Feb. 8, 1940 Md. Usual Rasidenca of Decedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at Md. n/a Baltimore toras 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5715 Park Heights Avenue Apt. 408 21215 USA Funeral death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haaith and Mentel Hygiena. Innportant: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Exercises pages. Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 3 ☐ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working tifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Flementary/Secondary (0-12) Collega (1-4or 5+) 12th Grade Elizabeth Clooney Private Duty Nurse 18. Mothar's Nema (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Be Rossie C. Grant Dorothy Sharp 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 2630 Marbourne Avenue Baltimore, Md. 21230 Dorothy Witherspoon Daughter 20b. Plece of Disposition (Nama of cametery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition March 2 Baltimore, Md. Arbutus Memorial Park 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funaral Sarvice Licansee derbert Lutter 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata fintarval Batween Onsat and Death **Physician** Immediata Cause (Final disaasa or condition rasulting In daath) /Medical Myccardo Examiner Due to (or as a consequenca of) Examiner attending physician end for usa es the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted avents rasulting In death) Last Dua to (or as a consaguanca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 98 signed by the a 23b. Did tobacco uss contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yss 2 No 3 Probably 4 Unknown g 24b. Wara autopsy findings available prior fo completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 s has 1 Yas 2 No 1 Yas 2 No certificate Attending Physician: director. 25. Was casa rafarrad to medical axaminar? 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitai: 1 Yas 2 No 1 Thpatiant <sup>o</sup>L 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) funeral 28d. Dascribe how Injury occurred 27, Mannar of Deeth 28b. Tima of 28c. Injury at Work? Certification: 5 Panding Invastigation Natural 1 ☐ Yas 2 ☐ No 24 hours after deeth. 2 Accidant 6 Could not be detarmined 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) filled in by 4 - Homicida ò Hospital 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, dete and place, and dua to the causa(s) end mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and mannar stated. 29a. Cartifiar edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Data signed (Month. Dav. Year) 29c. Licansa number 29b. Signature and titla of certifiar Phone and address of person who completed causa of death (Itam 23a) (Type, Print) 31. Data filed (Month, Day, Year) Dehider Drave Flus 10 240 2401 State FEB 2 8 2000 Registrar

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J ose	996-027 ph Jenk		3			nt in Black in aryland (-Dep MEO Ce			-	_	jible.	(1.12	
Al	Physici	an	5: #23 PART I, 27  1. Decedent's Name (First, Middle, Joseph Jun	Last)		MEO Ce	ertificate o	f Death	2. Date of Month	Death Day	Year 2000	3. Time of Death	
Examiner  4a Facility Name (If not institution, give street and number)  Howard Count Hospita						100			_	ocation of Death 4c. County		09:40 P.M	
	Funeral Director		5. Social Security Number 215-86-7001	6. Sex	Sex 7. Age (In		If Under 1 Yes   Months   Day	ar If Under 24 H	Irs. 8. Date of (Month,	Birth Day, Year) 7-69	9. Birthplace (State or Foreign Country)  MD		
	with the Maryland a or 28a-f ahow be notined at	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD NA			10c. City, Town or L Baltimo				10d. Inside City Limits			
	within 72 hours after deeth iens. The "naturel", or items 23		10e. Street and Number 322 Whitridg	e Aven	ue	10f. Zip Code 21218			ME	10g. Citizen of What Country? USA			
21215-0020			11. Marital Status  X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Every Armed Forces?  1				r in U,S.  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 Yes 2 No Specify:			No- 14. R B Spec	can Indian, , etc.		
			15. Decedenit: (Specify only highest Elementary/Secondary (0-12) High School	grade complete	College (1-4or 5+)		edent's Usual Occ e kind of work do DO NOT use ret employe	supation se during most of a red)		6b. Kind of Business/Industry Unemployed			
Maryland	ould be filed Mentel Hygi- mrked other mic event, in	17. Father's Name (First, Middle, Last)  Joseph Junior Jenkins, Sr. Belinda A.									Wilder		
Baltimore, Mar	Peges 1 end 2 shi tant of Health end rit: If Hem 27 le m iry or other treum		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   2121   3519   Holmes Avenue Baltimore, Maryland   20a. Method of Disposition   120   Date   20c. Location - City or Town, State   20b. Place of Disposition (Name of cametery, crematory or other place)   Date   20c. Location - City or Town, State   20b. Place of Disposition (Name of cametery, crematory or other place)   Kings Mem. Pk Cem   0.2 - 2.8 - 2.000   Randallstown Miles   2.000										
Balti	permit. Peg Depertment Important: I eny Injury o		4 Donation 5 Oother (Specify)  Kings Mem. Pk. Cem. Q2-28-2000 Randallstown  21. Signature of Funeral Service Learner  WM.C. March FH 1101 E. North Avenue										
	Physician /Medical Examiner	or.	23a. Part1. Enter the disease or shock, or heart tailure. Use Immediata Cause (Final disease or condition resulting in death)		HMA		iter the mode of o	ying, such as card	fiac or respirato	y arrest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death	
, P.O. Box 68760,	liceta be axecuted physician end is the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	C	Due to (or as a conse	equence of):				t		
	The law requires that the deeth certi- ate has been signed by the effending page 2 should be detached for use a		that initiated events resulting in death) Last	d	Due to (or as a consequence of):								
		by Physicia	Part It. Other algorificant condition	s contributing to	death bu	t not resulting in the	underlying cause	given in Part I.		Old tobacco use o		to the cause of death?	
ecords,		Completed b								Vas an autopsy erformed?	8	Vere autopsy findings vailable prior to ompletion of cause I death?	
ai R					1 X Yes 2 No 1 X Yes 2 No								
Vitai		o Be	25. Was case referred to medicat axaminer?  ↑ Yayes 2 No	Hospital:	26. Place of Death (Check only one)  Hospital: 1 □ Inpatient 2 ☑ EP/Outpatient 3 □ DOA  Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							6.1	
o	B . 55	cation: To	27. Manner of Death  1 Naturat 5 Pending investigation	28a. De (M) 2-1	28a. Dete of Injury - At home, farm, street, factory, office					28d. Describe how injury occurred EXPOSURE TO SMOKE AND FIRE			
Division	pital or Attend burs efter death eral Director: / filled in by the f	al Certification:	3 Suicide 6 Could no determine 29a. Certifier 1 Certifying	bu 288. Pit						28f. Location (Street and Number or Rural Floute Number, City or Town, State) PATUXENT INSTITUE JESSUP, MD			

\*IXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

O.C.M.E.

February 19, 2000

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

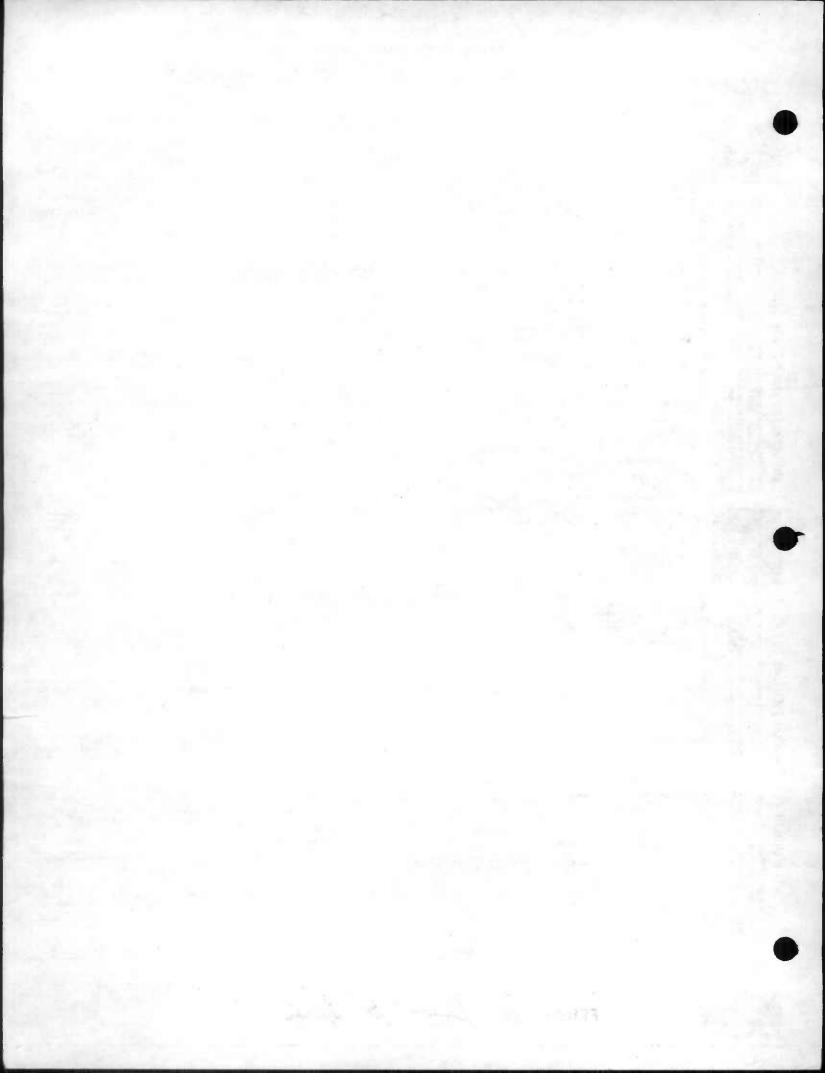
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31. Date filed (Month, Day, Year) 982. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

FEB28



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Helen Jakelski 24, 2000 12:01 PM 4c. County of Death FEBRUARY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Day, Year April 6,1926 6 Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 200 F 214-20-9194 73 Director Maryland Usual Rasidence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits

10f. Zip Code

Bel Air

1 ☐ Yes 2 K No

Approximate Interval Between Onset and Death

DAYS

DAYS

DAYS

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year)

10g. Citizen of What Country?

the Maryland r 28a-f show ahow ma 23a or With death Noma 2 filed within 72 hours after ò "natural". Hyglene. other than "nature ent, the Medical I

21215-0020

Baitimore, Maryland

Director

Maryland

10e. Street and Number

Harford

. Pages 1 and 2 should be filt ment of Heelth and Mental Hyant: If Item 27 is marked oth jury or other traumatic avery Department of Important: If any Injury or pace.

**Physician** /Medical Examiner

that the death certificate be executed physician and the burial-tran Box 68760. 88 987 P.O. Records, 50 The law requires page 2 of Vital Physician: After this Division

or Attending r death. 24 hours after deat Punerel Director: filled in by Hospital To the To the F

1321 Sweetbriar Lane 21014-2254 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Datas; Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Ves 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Jakielski Anna Keefer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stanley Jakielski/Brother 1321 Sweetbriar Lane Bel Air, Maryland 21014-2254 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 2/28/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231 ave 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in death) SEPTIC SHOCK Due to (or as a consequence of): Examine RESPIRATORY INSUFFICIENCY Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): FAILURE RENAL Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown MYOCARDIAL INFARCTION þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? LACTIC ACIDOSIS 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 . Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signa

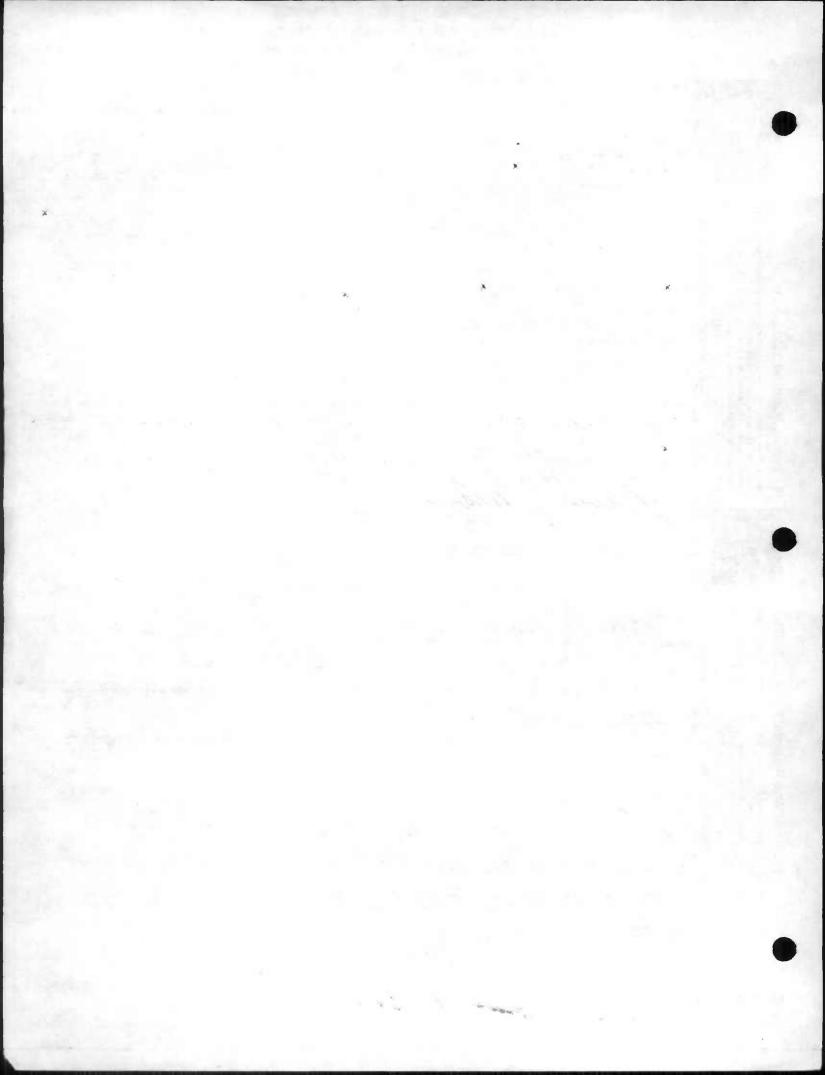
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD LINTHICUM, M.D.,

29c. License number

D31826

OSLER DRIVE, TOWSON, MARYLAND



Examiner

11:00 AM

**Funeral** 

Director

#Pow Directo 'natural', or flams 23s or 28s-f Funeral Completed

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88

hours after Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic even and

altimore, Maryland 21215-0020

**Physician** /Medical Examiner

Examiner physician and the burief-transit that the death certificate be assecuted Box 68760. Physician/Medical 080 P.0. signed b Records, by should Completed hes 62 certificate of Vital Be Certification: To this Division

Attanding after deeth. 8 24 hours To the Within 2

SLENWOOD JONES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Tima of Death Dev Month Year February 23, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 8. Dete of Birth (Month, Day, Year) JAN 15, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months M 2□F 212-30-7723 67 Yrs 1933 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code t0g. Citizen of What Country? 7080 Cradlerock Way 21045 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: specify: White 3 ☐ Widowed 4 ☼ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Steel Mil] 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Frank R. Jones Elizabeth Preister 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Hayes/sister 7934 Nottingham Way Ellicott City, MD21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/25/00 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, 21. Signature of Funeral Service License Thomas Gre Inc. 299 Frederick Rd. Baltimore, Gregor 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart lailure. List only one cause on each line. Approximate Intervel Between Onset and Deeth A FeW Immediate Cause (Finel Minutes EXSANGUINATION disease or condition resulting in death) A Few Due to (or es e consequence of): PERFORATED LEFT LINGUAL ARTERY Minutes A Few-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Several SQUAMOUS CELL CARCINOMA, LEFT OROPHARYNX Months Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en autopsy

24b. Were autopsy findings aveilable prior to completion of cause of death?

Yes 2□ No

2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only

29c. License number 29b. Signature and title of certifies D48054

29d. Dete signed (Month, Day, Year) February 24, 2000

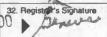
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) r J. Ross Slemmer St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

Registrar

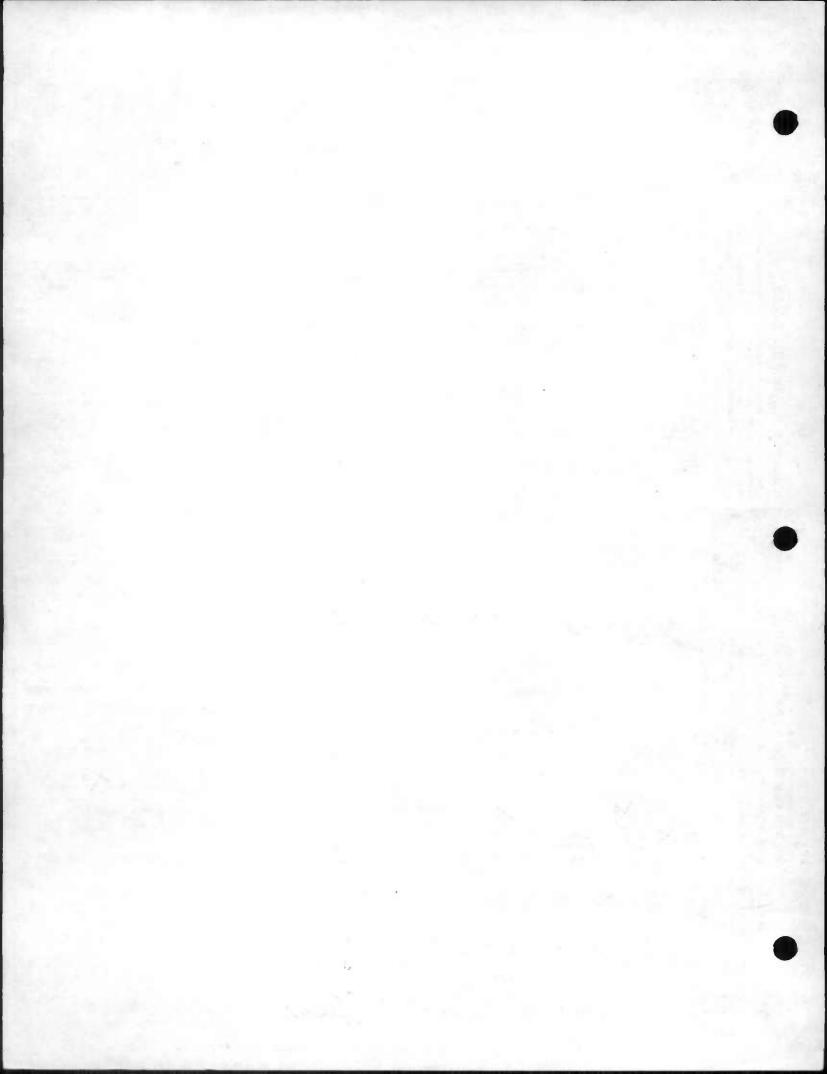
Medical

31. Date filed (Month, Day, Year) FEB 2 8 2000

4 Homicide





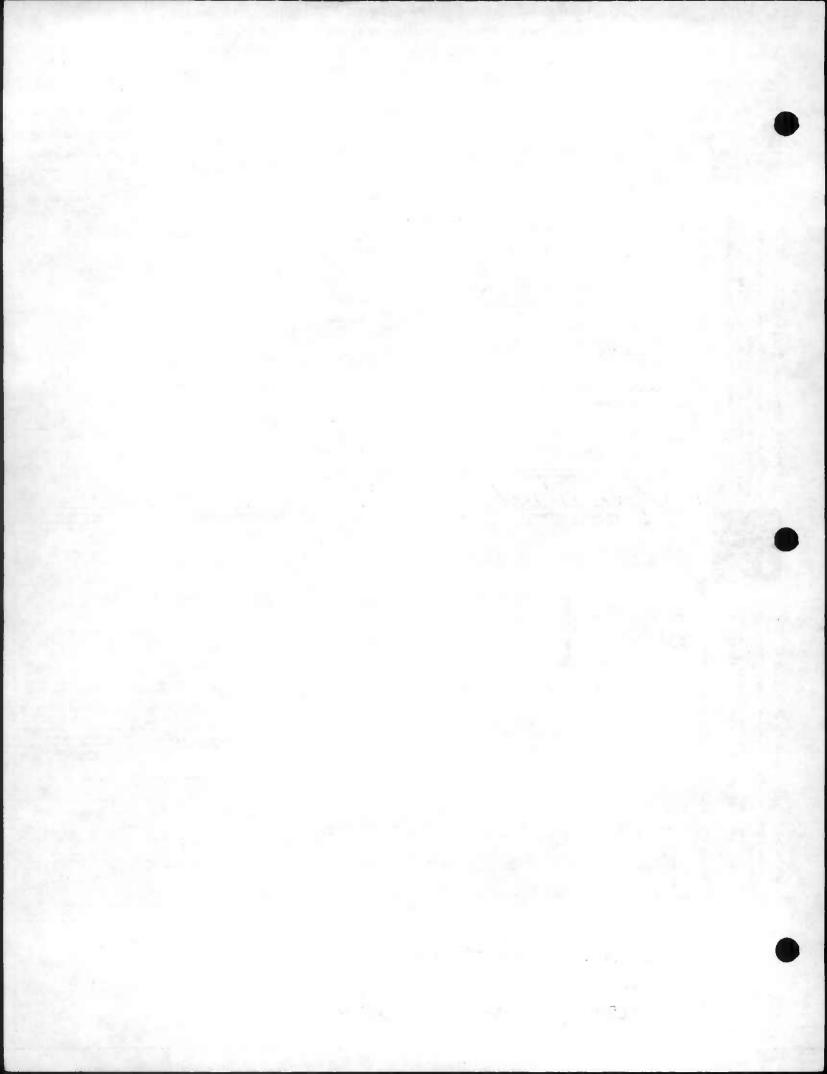


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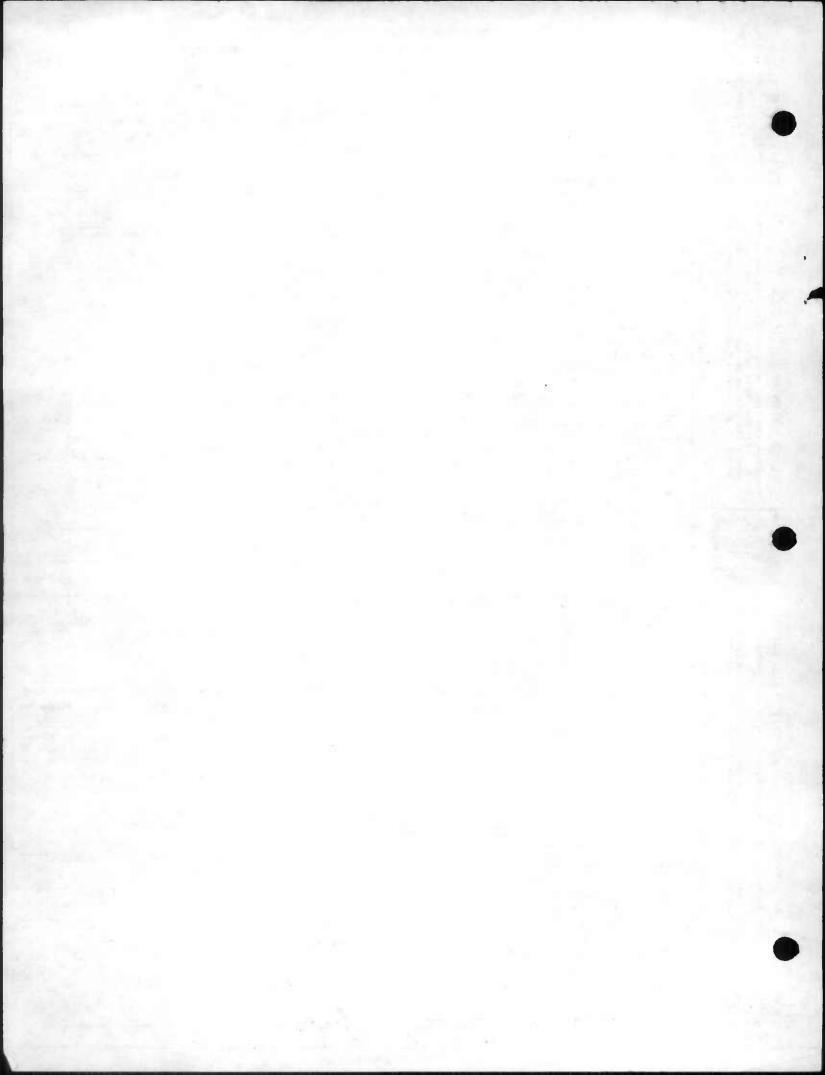
State of Maryland / Department of Health and Mental Hygiene 00 064 15

						Ce	ertifi	icate of	Death			Reg. No.	0	0410
	B: ::	1. Decedent's Neme (First, Middle, Last)								2. Date of I			Year	3. Time of Death
	Physician /Medical			Dawi	1	Joh	ns	on			Februa	Day		9:04 P.M.
	Examiner	4e Facility Name (If not inst			mber)					-	cation of Deat	1	2000 nty of Death	
_		2609 Smith Avenue Mt. Washing										ltimo		
	Funeral Director	5. Social Security Number  216-37-8902  Usual Residence of Deceda		ех □м 2√2 F	7. Age (III	yrs. last birthda) Yrs.		onths Days	Hours	Min.	8. Date of Bir (Month, De 12-7-	1979	9. Birth	nplace (Stata or Foreign intry) Md
aryland	/land	10a. Stete 10b. C			10	c. City, Town or L	Locatio	on	96.5					10d. toside City Limits
	Man	Md N/A Baltimore									12			
	or 28s-fa be notified be notified	10e. Street and Number 10f. Zip Code										10g. Citizen	of What Cou	intry?
	with w	4044 Edgew				21215			USA					
21215-0020	72 hours after death with the Maryland natural; or items 23a or 28a-f ahow dies. Examinal, must be notified at seed by Funeral Director.	11. Meritel Stetus 1  1 Never Married 2 Married 3 Widowed 4 Divorced		Armed Fr	12. Wes Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		S. 13. Wes Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 3 ☐ No Specify:			n, Puerto	o Rican, etc.)		Race - American Indian, Black, White, atc.	
5-0	ed within 72 hours ygiene. Ar then "natural", A. the Medical Ex Completed by		15. Decedent's Ed (Specify only highest grad			16a. Dec	edent'	's Usuat Occup i of work done	pation during mos	st of work	ina	16b. Kind o		
121	c 1 4 -	Elementary/Secondery (0	Elementary/Secondery (0-12)		1-4or 5+)	life.	DO	NOT use retire	d)			Cosmo		gy
7	other than vent, the M	12th grade		N/	A		50	udent	18 Moth	or's Nams	/First Middle			
Marylan	Mental Hygarked otheratic avent,	Withrow Jo						18. Mother's Nama (First, Mi						
		19e. Informent's Neme/Reto				19b. Mai	iling A	ddress (Street			al Routa Numb		wn, State, Z	ip Code)
	d d d d d d d d d d d d d d d d d d d	Esther Joh	nsor	- Mo	ther									
Baltimore,	80 - 7	20a. Method of Disposition 15 Burial 2 Creme 4 Donetion 5 Oth	tion 3 E	Removel from		Rob. Place of Disposementary, crick ing Me	emato	ery or other pla	œ) Park	2	Date 20c. Location - City or To 20c. Randalls		own, Stete .stown, Md	
Baltir	permit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Licensee  22. Name and Address of Fecility  March F/H West											21215	
	Physician /Medical Examiner	23a. Pert1. Énter the disea shock, or heert feiture Immediate Cause (Finel disease or condition resulting in daeth)	List only		d and	l Neck In	nju	ries					1	tritaryat Between Onset end Deeth
x 68760,	death certificate be executed a strending physician and of or use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if sny, leeding to immadieta causa. Entar Underlying Cause (Disease or hijury that initieted events rasulting in death) Lest	{	c		to (or as a conse								
S. Box	at the death ce d by the attendi etached for use Physician/	Part It. Other significant co	nditions o		eath but no	ot resulting in the	under	nying cause gi	ven in Pert	l.	23b. Did	tobacco use	contribute	to the cause of death?
P.0	res that the de signed by the sidned by the sidned if be detached if by Physical										1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ◯ VU			
of Vital Records,	been should										performed? eva		Were eutopsy findings ovailable prior to completion of cause of death?	
R	The law page 2 page 2										1 🔯	Yes 2 N	. 1	ŊYes 2□ No
ital	certificate rector, pa	25. Wes case referred to m	dical						26. Plac	e of Deet	h (Check only			
>	7 00	examinar? 1 XYes 2 No		Hospitel: 1	Inpetient	2 ER/Outpatio	ent 3	3 DOA Ot	her: 4 N					in) at scene
<b>Division</b> o	ath. r: After ne fune	27. Manner of Death  1 Neturet 5 P  2 Naccident	ear) tnjury	28b. Tima of tnjury M 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No					28d Describe how injury occurred Subject was passenger in vehicle in a vehicular accident.					
Divi	To the Hospital or Attended within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	3 Suicide 6 Could not be determined 28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify)								City or To	281. Location (Street and Number or Rural Routa Number, City or Town. State) 2609 Smith Avenu Mt. Washington, Maryland.			
	n 24 hound n 24 hound he Funer pletely fil			niner: On the b		y knowledge, dee aminetion and/or i								
	To the Comp	29b. Signature and title of c	ortifiar /	1 K		/		29c. Licen	se number .C.M.]	Ε.				o, Day, Year)
	5	30. Name and address of per Theodore Ki			se of death				Stree	t, Ba	altimor	e, Mar	yland	21201
	State Registrar	31. Dete filed (Month, Day, FEB 2	(ear)	32. F	egistrer's	Signeture /	/	Spark.	_			,		

DHMH 16 Rev 6/95



**ORIGINAL** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death TOHNSON Year Month CLAUDIA 19:00 FEBRUARY 2000 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Security Number 6. Sex 7. Aga //n vrs City BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Months 10 M 200 081-46-7871 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA BATTimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2555 45A 13 Street 12. Was Decedent Evar in U.S. 21217 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. Specify HV Con Armed Forces? 1 Never Married 2 Married 1□ Yas 2 Ko Specify: Yas, Giva Year or Datas: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th NK 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) ElVie JOHNSON JOHNSON Vames 19a. Informant's Name/Relationship (Type, Print) Parther 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Johnson James 2555 BATTIMON, MD. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Peremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crenatory February 28 1000 Cotons Ville 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility N. Gilmon Street 23a. Part . Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death INTRACRANIAL HEMORRHAGE Immediata Cause (Final 24 hrs diseasa or condition rasulting in death) Due to (or es a consequence of): 24hrs COAGULOPATHY Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ahow

the Madical Examiner must be notified at

"natural", or items 23a or

al Hygiene.

. Pages 1 end 2 should be fil ment of Health and Mental H ant: If Itam 27 la marked off lury or other traumatic avan

Department of H Important: If its any injury or oth pace.

filed within 72 hours after

Baltimore, Maryland 21215-0020

W

Director

Funeral

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Completed

Be

Examiner Physician/Medical Completed by Be edical Certification: To

physician and the bunal-transit signed by the this

the death certificate be executed Box 68760, P.O. Records, Division of Vital Attending Physician: within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fu 6 Hospital

within 2

Registrar **DHMH 16 Rev 6/95** 

(Check only one)

20b. Signature and title of estation

31. Data filed (Month, Day, Year)

FEB28

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acquired Immuno deficiency Syndrome 24b. Were eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Pneumoccocal Pneumonia 1 ☐ Yes 2 No 1 Yas 20 No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 11 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide 29a. Cartifier

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Data signed (Month, Day, Year)

00054031 MD

FEBRUARY 26, 2000

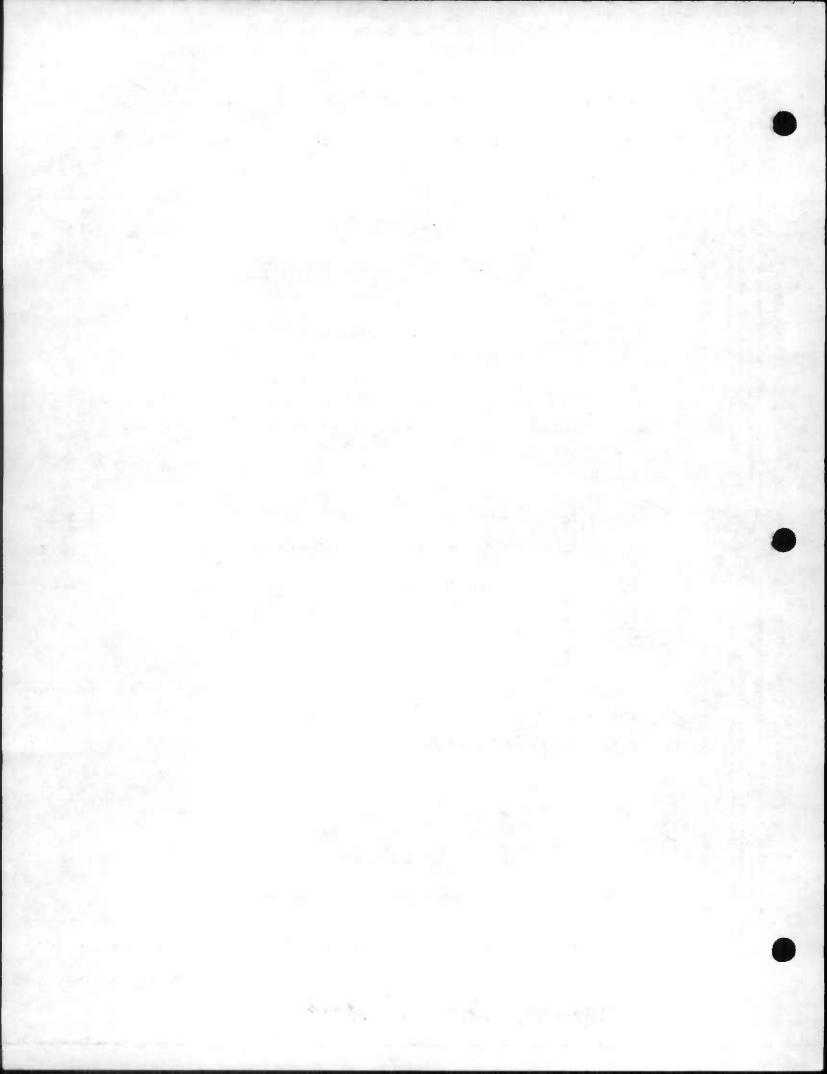
HOSPITAL

30. Nama and address of page who completed causa of death (Item 23a) (Type, Print)

GEO CADIN, MD - JOHNS HOPKINS

ROMERGRYKO 6.

32. Registar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06418 Certificate of Death 1. Decedent'a Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** February 24, 2000 Benjamin C. Kohlhafer 4:30 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Care Center Baltimore If Undar 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) 8-16-1911 7. Age (In yrs. last birthdey) **Funeral** Months Days 1 M 2 F Yrs 215-10-4244 88 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limita "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Baltimore Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 8820 Walther Blvd. Apt. 3507 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Supervisor Western Electric 8 important: If item 27 is marked other any injury or other traumatic avent, the once. 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Heelth and Mental Kohlhafer Edna Mills Benjamin 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 408 Century Vista Drive, Arnold, Maryland Mr. Richard C. Kohlhafer (Son) 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2-28-00 Elkridge, Maryland 21. Signature of Funaral Sarvice Licansee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. Brooks Wallace 1050 York Road, Towson, Md. 21204 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical PROSTATE CANCER Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) physician s the burial P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): S (5) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably Unknown 1 Yes 2 No Records. λq 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 ☐ No Division of Vital Mospital or Attending Physician:
 24 hours effer death.
 Funeral Director: After this certifical. director, 25. Was cese referred to medical examiner? 8 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Dey, Year) 25643 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bud/ Bolto MD 21234

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Dey, Year)

**ORIGINAL** 

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8800 Walther

32. Registrar's Signature

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DESCRIBE STATES

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lillian V. King February 24 2000 4:00PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1211 Leonard Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 79 Yrs. 1□ M 2⊠ F 217-18-1330 Director Dec. 06 1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or litems 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zto Code 10g. Citizen of Whet Country? 21060 1211 Leonard Drive USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black White etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Head Cashier Department Store permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Itam 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Zielonka Lillian Kochanski 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janet M. Rainier (daughter) 1211 Leonard Drive, Glen Burnie, MD.21060 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Feb. 28 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cemetery Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livent 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 23a. Part1. Enter the dise shock, or heart failure **Physician** Concer - STage TV /Medical Immediete Cause (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 100 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach. 1 Yes 20 No 3 Probably 4 Unknown p 24b. Were autopsy findings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: in thin 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Naturat 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homictde Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ans 027938 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1. A STA CAR RATY MP TY SAQUAHARTRO. GIEW BUNNE, MO 21061 32. Registrar's Signeture

**DHMH 16 Rev 6/95** 

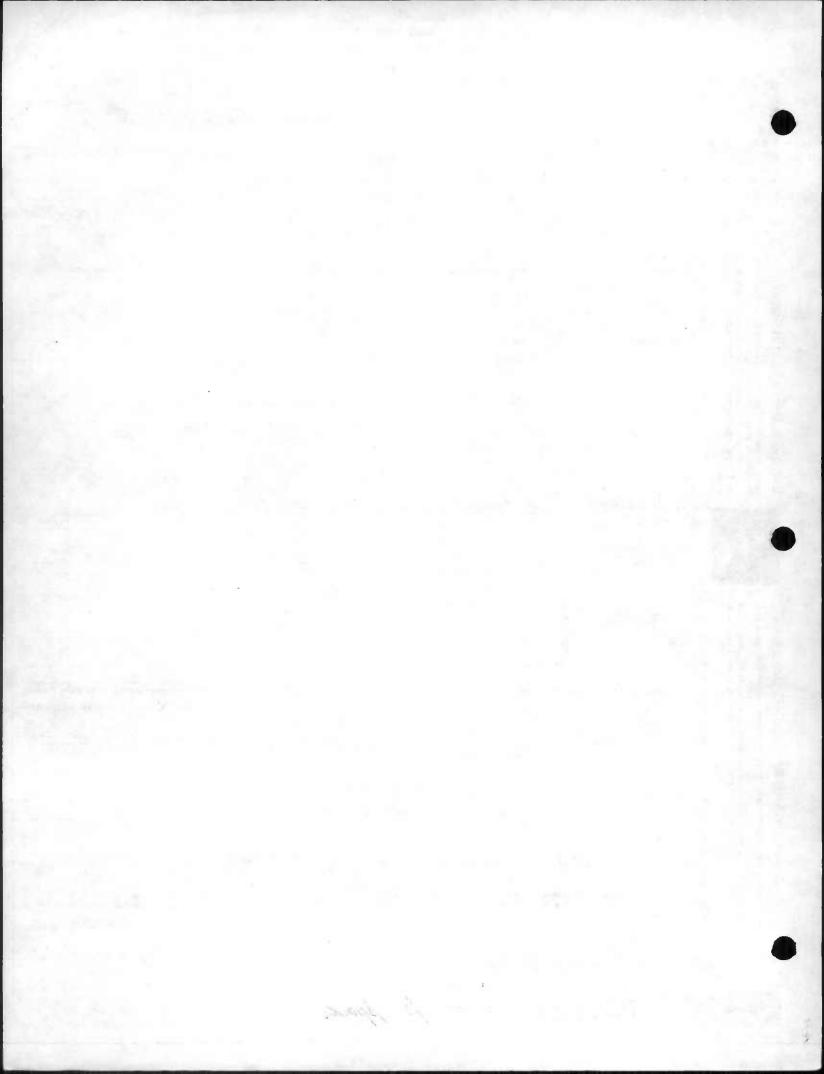
State Registrar

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Physician Knight 7:40 AM Hannah 4b. City, Town, or Location of Death 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore HOSPital 6. Sex Baltimore Sinau N/A If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 20 F Hours 217-09-9462 Director 81 unknown Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examinar must be notified at 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Pall Mall Road Funeral 21215 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be illed within 72 ho nent of Health and Mental Hyglens. ant: If Item 27 Is marked other than "natur ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2401 W. Belvedere AVe Baltimore, MD 21215
of Disposition (Name of Date 20c. Location - City or Town, State Sinai Hospital
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Furieral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street de Director Mory 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, anock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examine Physician/Medical Examiner winary tract infection attending physician and for use as the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1/035/ve Myo cardial infarction, Due to (or as a consequence of): Box 68760. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Parkinson's disease Records, þ The lew requires 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed History of cerebrovasevlar accident Coronary artery disease, Hypertension 20.No 1 Yes 2 No certificata of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Division 1 Matural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Tes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 🗺 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deepal Kashupp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepal Kashyas St. 31. Date filed (Month Pay, Year) FEB 2 8 2000 Sinai Hospital of Battmore 22-101 West Beliedere Avenue Battimore, My 21715 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

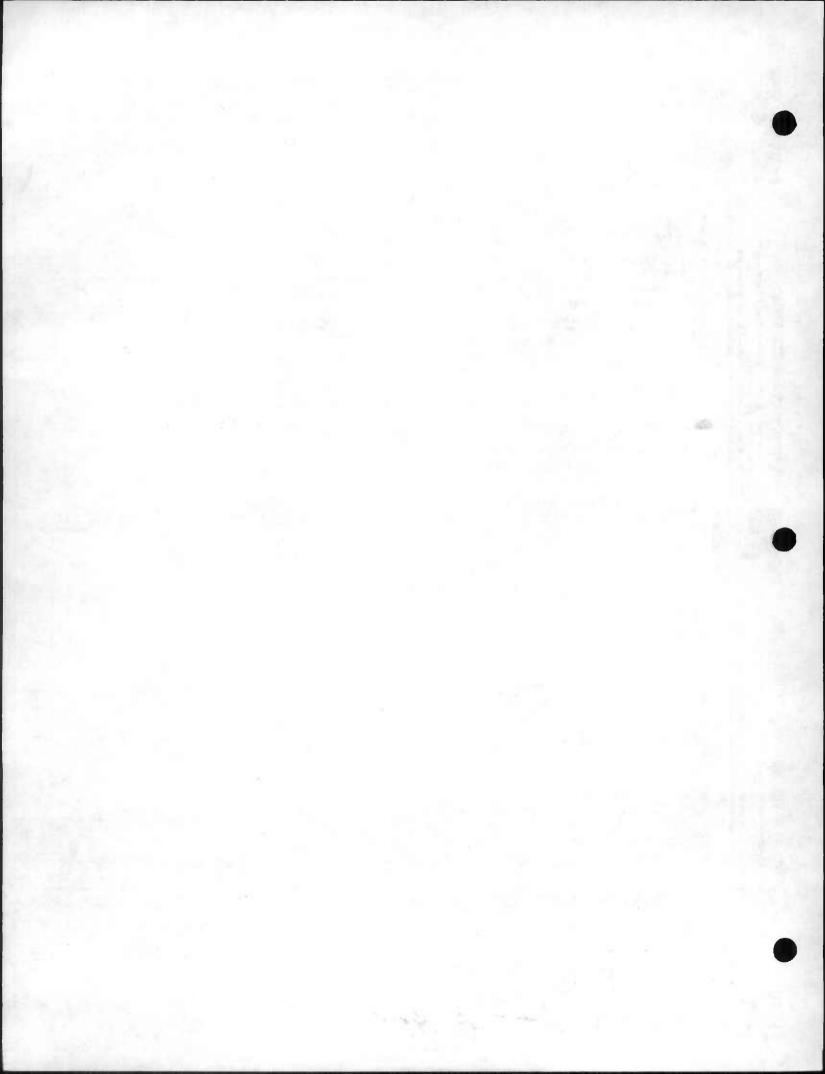
Registrar



Ple	ase Type or Print in E State of Marylan		t of H	lealth and M	lental Hyg	_	06421			
1. Decedent's Name (First, Midician	dle, Last)				2. Data of Dea Month	ith Dey	3. Time of Death			
dical GEOKGE LITTLE					FEBRI	JARY 1	1,0			
ilitiei	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of De									
UNION MEMOR  5. Social Security Number	AL HOSPITAL  6. Sex / 7. Age (In yrs.	last hirthday) If Under		BALTIMORE  If Under 24 Hrs.			N A			
214-16-5966	12 M 2□ F 80	Yrs. Months	Days	Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)  VA			
Usual Residence of Decedent					00 02					
10a. State 10b. Coun		TMORE					10d. Inside City Limits			
10e. Street and Number  10e. Street and Number  11. Marital Status  11. Never Married 2 Mar	3.3	1 ☐ Yes 2 ☐ No								
10e. Street and Number		10f. Zip		1 -		10g. Citizen of What Country?				
4 UPLAND ROA	<del>"</del>		212	•	7 7	USA				
11. Marital Status  1 ☑ Never Married 2 ☐ Ma	12. Was Decedent Ever in U. Armed Forces?	,S. 13. Was Deced	ify Cuba	ispanic Origin? (Spann, Mexican, Puerto	Rican, etc.)	Bled	e - American Indien, ck, White, etc.			
3 Widowed 4 Divorce	If Yes, Give	12 Yes	2□ No	Specify:		Specify	WHITE			
	ont's Education	16a. Decedent's Usua	d Occup	ation		16b. Kind of Bu	usiness/industry			
(Specify only high Elementary/Secondary (0-12)	est grade completed)	(Give kind of wo	rk doné d se retired	during most of works	ing					
Continuity/Socordary (0-12)	Comage (1-401 54) ELIV	CHECKE	ER			ME	EDIA			
17. Father's Name (First, Middle	e, Last)			18. Mother's Name		Maiden Suman	18)			
GEORGE LITILE				FLORA F	ORD					
19a. Informant's Name/Reletion		19b. Mailing Address				r, City or Town,	Stete, Zip Code)			
JAMIE WESTRIC		1731 BOLTON		T., BALTO	. mo.	21217	17			
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion	3 DRemoval from State	Place of Disposition (Nar. cometery, cremetory or of ETRO CREMATO	ther piec		Dete		City or Town, Stata			
4 Donation 5 Other	ORE, MO									
21. Signature of Funeral Service	e Licensee	22. Neme en	ON S	SERVICE						
Vayer	or complications that caused the deat at only one cause on each line.	5151 BAL	0. N	ATL PIKE,			Approximete Intervel Between			
Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other eignificant condit	b. Due to (c	or as a consequence of):  Proud hor as a consequence of):  or as a consequence of):	ista	en Sy	gndro	me	15 day			
Part II. Other significant condit	ntribute to the cause of death									
noun	onia, Hill	IV, CA	W.	1			1			
COPI	D, PVD,	aiB(	00	d	24a. Wes a		24b. Were autopsy findings available prior to completion of cause of death?			
					70 Y	es 2□No	1 ☐ Yes 2 No			
25. Was case referred to medic examiner?			Tai	26. Place of Deet	h (Check only o	ne)				
1 Yes 2 No		ER/Outpatient 3 DC		4 U Nursing Ho						
27. Manner of Death Natural 5 Pend		28b. Time of 2 Injury M	8c. Injun	yet k? Yes 2 No	28d. Describe h	low injury occur	red			
3 Suicide 6 Coul					28f. Location (S	Street and Numb	ber or Rural Route Number,			
4  Homicide	building, etc. (Specif	y)	, 000		City or Tow					
	ing Physician: To the best of my kno	wledge, death occurred	et the tin	ne, date end place.	and due to the o	cause(s) and me	enner es stated.			
	Examiner: On the basis of axamina and manner stated.									
29b. Signature and title of certif	er CV - A1	290		e number	01 1	29d. Dete signe	d (Month, Day, Year)			
Ritu	K shetty	mo A	ナ	2438	9461	EBRU	ARY 19.2007			
30. Name and address of perso	n who completed cause of death-(Item	n 23a) (Type, Print)	2	1 0	11					
Un	ian Mammie	1 Hom	le	21,16	altri	more	, 2/2/8			

DHMH 16 Rev 6/95

State Registrar



#### Please Type or Print in Black Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Dev Month Frank Joseph Lantiere February 22,2000 4:02 a.m. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale If Under 24 Hrs. Franklin Square Hospital Center Baltimore Birthplace (Steta or Foreign Country) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months Hours tXXM 2□ F Yrs. 215 14 9355 76 Jan. 5, 1924 Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yas 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Homberg Avenue 21221 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yas 2 XNo If Yas, Giva 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Machine Mechanic Building Products 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Rose Lantiere 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy Lantiere (Wife) 112 Homberg Avenue Baltimore, Md. 21221 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Gardens Of Faith Cemetery 2/25/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Bruzdzinski Funeral Home, P.A. 23a. P. L. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximete Approximete Approximete Intarval Batween Onset and Death 2 days MYOCARDIAL INFARCTION Immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Due to (or es a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? oulmonary disease Yes 2 No 3 Probably 4 Unknown obstructive 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformed? complation of causa of death? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case reterred to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

**Physician** /Medical Examiner

permit. Pege Department of Important: If any injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

na 23a or 28a-f show mant be notified at

Nema :

"natural", or

Peges 1 and 2 should be filed within nent of Health and Mentel Hygiene. ant: If flem 27 is marked other than ury or other traumatic event, the Mentel of the

Director

Funeral

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Completed

Be

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with the Maryland

death

filed within 72 hours efter

altimore, Maryland 21215-0020

physician is the burial signed by the at I be detached for The law requires this funeral After

P.O. Box 68760.

Division of Vital Records.

or Attending ster death.

Examiner Physician/Medical à Completed Be Certification: To

1 Yas 2 No

5 Pending

Invastigation 6 Could not be determined

27. Mannar of Death

1 Natural
2 Accidant

3 Suicide

29a, Certifiar

Medical

4 ☐ Homicida

(Check only one)

Hospital 24 hours To the Hosp within 24 ho To the Fune completely fi

Registrar

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura and titla of certifie

28a. Data of Injury (Month, Dey Year)

18326

💢 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Data signad (Month, Day, Year)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

28d. Describe how Injury occurred

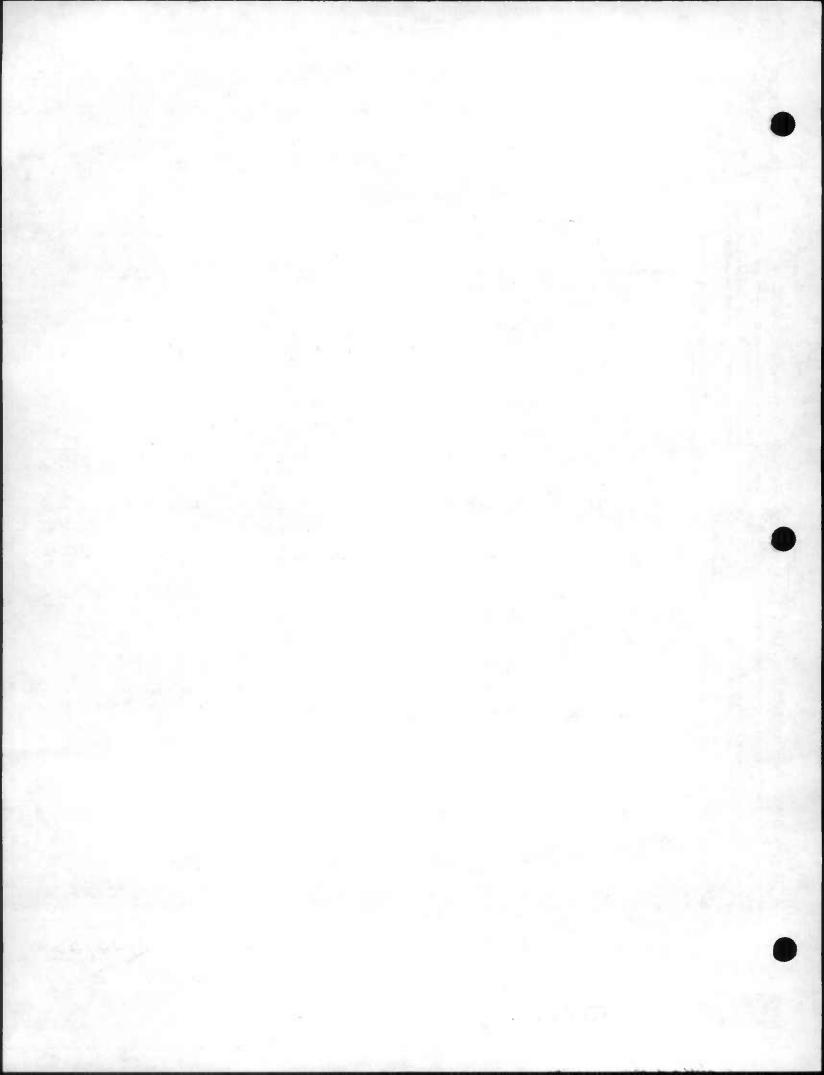
30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Medical Center falt. MD 2122/

GAUHAR, ESSEX 31. Data filed (Month, Day, Year)

32. Registrar's Signatura FEB 2

28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Evelyn M. Lindsay 24, 2000 Feb. 5:30pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 2121 Windsor Garden Lane Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Hours 1□ M 2₩ F Months 219-30-8644 MD 02-28-22 Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits t ☐Wes 2 ☐ No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 Windsor Garden Lane 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2/XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland School for the Blind House-parent 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Н. Wilson Elizabeth Gough 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07024 19a. Informant's Name/Relationship (Type, Print) 2175 Hudson Terrance Apt.4-L Fort Lee, NJ Joyce Μ. Jones 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete ★Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Voshell Mem. Gardens 02-29-2000 Dundalk, MD 22. Name and Address of Facility 21 Signature of Funerat Service Licenses 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2a WM.C. March FH 1101 E. North Avenue Approximate Interval Batween Onset and Death Immediate Cause (Finel Massive disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 Ne 27. Manner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Deturat 1 | Yes 2 | No 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 6 Could not be 3 ☐ Suicide

attending physician and for use as the burlei-transit or Attending Physician: The law requires that the death certificate be assecuted Box 68760. signed by the a P.O. of Vital Records, certificate this funeral After Division

Physician/Medical Examiner Certification: To 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

must be or

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. Pages 1 and 2 should be fit the most of Health and Mental H tant: If Nem 27 is marked off jury or other traumatic even

Department of Important: If any injury or abba.

**Physician** /Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after

21215-0020

Baltimore, Maryland

Completed by Be

within 24 hours after death. To the Funeral Director: Af Hospital edical ptaly To the

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) State Registrar

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifie

FEB 2 8 2000

30. Name and address of person who completed cause of death (trem 23a) (Type, Print)

Vasanthakumar

32. Registrar's Signeture

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

M. VASANTHALCUMAR, 821. N. EUTAWST

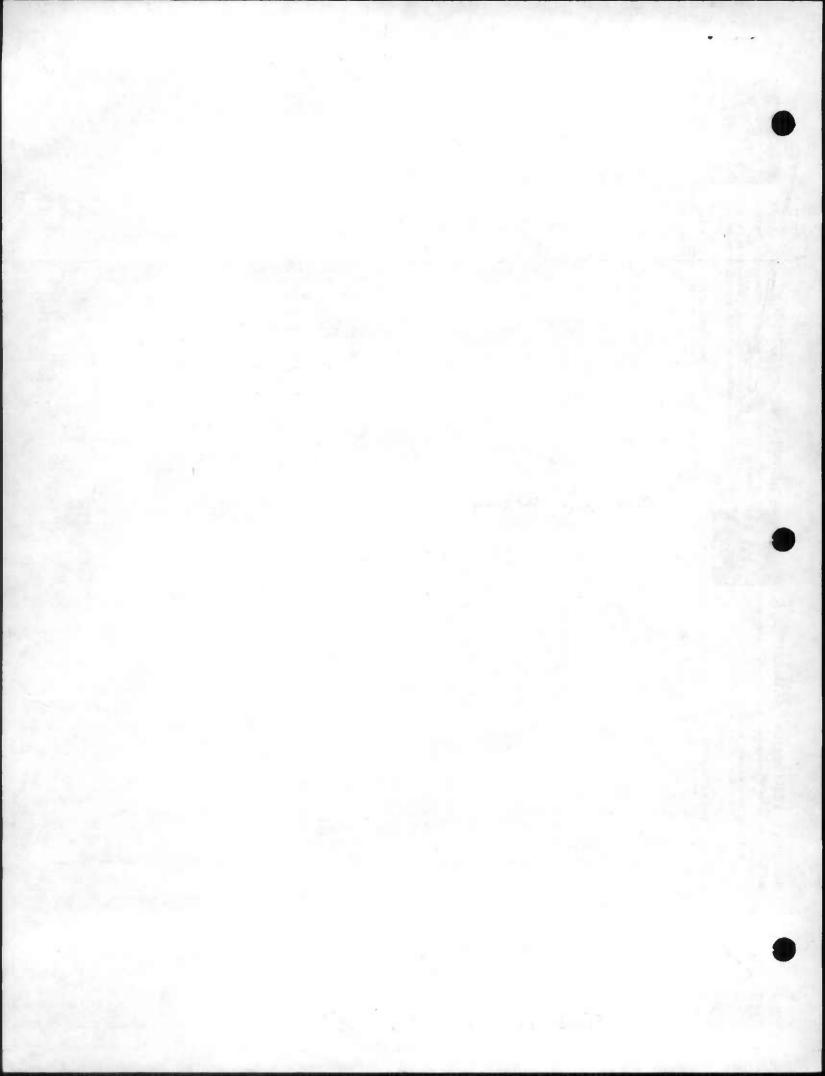
29c. License number

D42510

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

# 407, MD2120



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Maurice M. Lane February 26, 2000 6:00 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6606 Blackhead Rd. Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 8, 1909 Birthplace (Stete or Foreign Country)
 New Jersey 7. Age (In yrs. last birthday) **Funeral** Months Days 12 M 2□ F 215 07 8142 91 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or Nems 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 6606 Blackhead Rd. 21220 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Evar in U.S. Armed Forces? hours after 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Giva altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within 72 hann of Heelth and Mentel Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Mail Clerk 12 Insurance Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unk. unk. 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Blair Lane (Son) 6606 Blackhead Rd. Baltimore, Md. 21220 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition cematery, crematory or other piece, 1 2 Burial 2 Cremation 3 Removal from State Moreland Mem. Park 3/1/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensi 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, ations that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, cause on each line. 23a Part Enter the disease, or compliance, or heart failure. List only or **Physician** /Medical Immediate Cause (Final METASTATIC BLADDER CANCER YEARS disaese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examine LUNG METASTASES YEARS be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last ettending physicien and for use es the burial-tran Due to (or es e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 2000 1 Yes 3 Probably 4 Unknown ANEMIA. Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? page 2 s 1 Yas 2 XNo 1 □ Yes 2 □ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Mesidence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 2 4 Homicide 5 To the Hospital of within 24 hours of To the Funeral D completely filled I 29e. Certifier Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifier D.O. H35593 FEB. 28, 2000 30. Name and address of person who completed quuse of death (Item 23a) (Type, Print)

Registrar

State

DR. J 31. Date filed (Month, Dey, Year) FEB 2 8

JOHN J.

2000

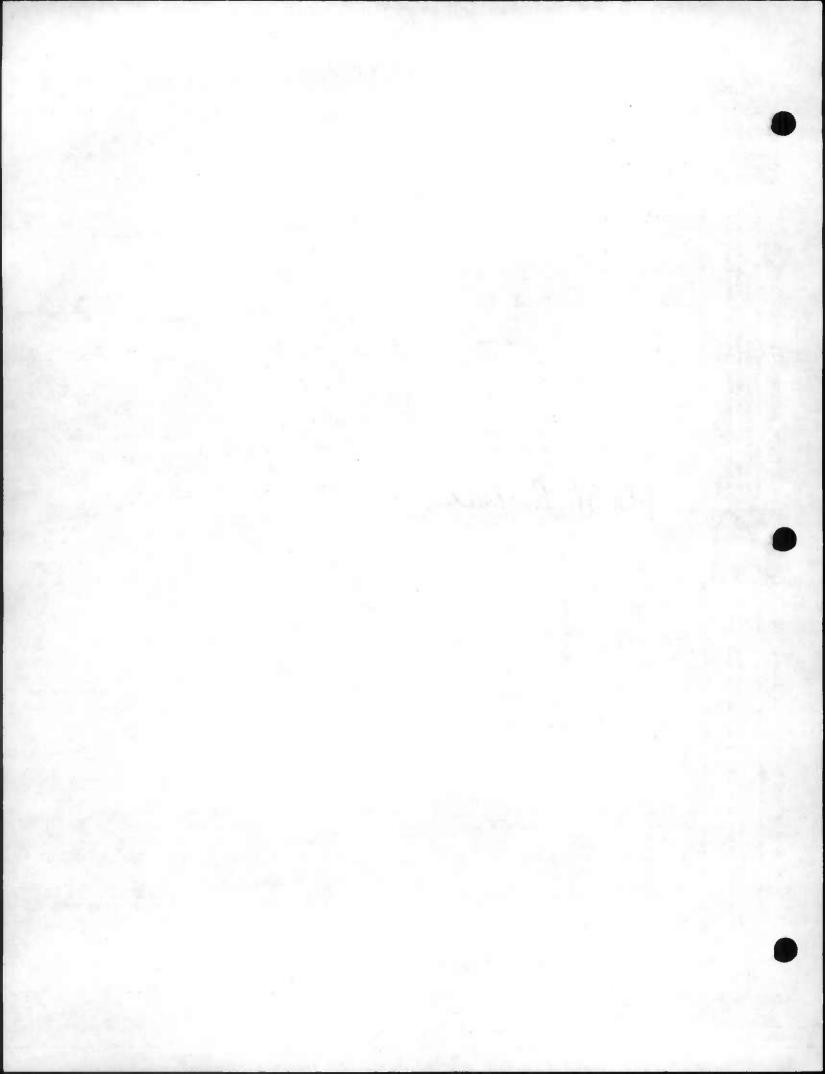
LOH 1124

32. Registrar's Signature

DHMH 16 Rev 6/95

**ORIGINAL** 

MACE AVE., BALTIMORE, MD. 21221



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth David Lipton FEB. 2000 8:20am 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Center Gilchrist Baltimore If Under 1 Year | If Under 24 Hrs. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 10 M 20 F Yrs. 116-12-5947 OCT. 10, 1917 New York 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10799 Hickory Ridge Road 21044 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ₩ Merried 1□ Yes Y□ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manager Super Market 10 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Solomon Lipton Unk. Rose 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Ann DiLorenzo/daughter 10576 Cross Fox Lane Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 4 Donetion Metro Crematory, Inc. 2/25/00 Baltimore, MD 21. Signeture of Funeral Service License 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final CAncer Lung disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e consequence of):

**Physician** /Medical Examiner

should be det

funeral director.

P

Completed

edical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

r than "natural", or items 23s or 28s-f the Medical Examiner must be notified

72 hours after

1 and 2 should be Health and Mental

tebruary 24,2000 e

Pton

Maryland

Baltimore.

P.O.

Division of Vital Records,

or Attending Physician:

Hospital

24 hours after deeth. Funeral Director: A

within 2 To the I \$

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CANCER

32. Registrar's Signature

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed?

1 Yes 2 No

24b. Were sutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

1 ☐ Yes 2 🗷	lo	Hospital: 1 Inpatient	2 ER/Outpatient	3□	DOA Other:	4 ☐ Nursing H	lome 5 Residence	6 Ather (Specia	mitos,	0
27. Menner of Death 1 XNeturel 2 ☐ Accident	5 Pending investigation	28a. Dete of Injury (Month, Day Y	28b. Time of	М	28c. tnjury at Work?		28d. Describe how inj			
3 ☐ Suicide	6 Could not be determined	e 28e. Place of Injury	- At home, ferm, stree	et, fect	28f. Location (Street and Number or Rural Route No					

29e. Certifier

25. Was case referred to medical

tid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

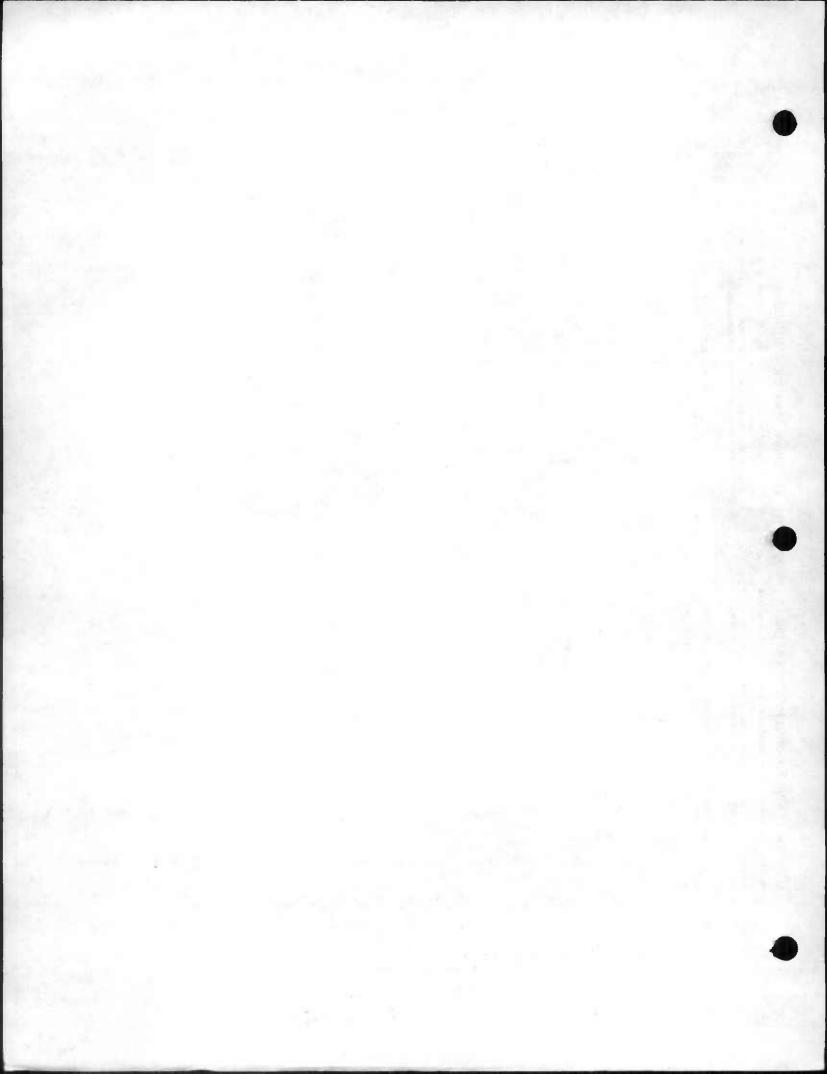
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and affle of orinitie 29d. Date signed (Month, Day, Year) 29c. License number

en 23a) (Type, Print) 31. Date filed (Month, Def. Year) 2 8 2000

Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06426 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dey **Physician** DUOITY Louise Kathryn Engelhart /Medical 4b. City. Town, or Location of Deeth 4. County of Deeth icility Neme (If not institution, give street and number) **Examiner** Baltimore
If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Feb. 8, 1917 9. Birthplace (State or Foreign Country) Pennsylvania 5. Sociel Security 7. Age (In yrs. lest birthd **Funeral** Deys Hours Min. 1 □ M 2 🗓 F 83 Yrs Director 215-24-4828 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No Maryland Baltimore Randallstown Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number "natural", or items 23a or adical Examiner must be n 9211 Turnbull Road United States
14. Reca - American Indien, 21133 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 Yes 27 No It Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: à White 3 ₩idowed 4 Divorced Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementery/Secondary (0-12) Coltege (1-4or 5+) Clerk Administration 12th 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be 2 Ħ is marked 2 Harry Alvin Niedenthol Pages 1 and 2 should Elizabeth Irene Delosier 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intorment's Neme/Reletionship (Type, Print) Arlene Nancy Davidson (daughter) 5629 Johnnycake Rd. Baltimore, Maryland 21207 reportant: If Item 27 Saltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition ъ 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8 Lake View Memorial Park Feb. 21, 2000 Sykesville, MD 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signeture of Funerel Service Licanses 8728 Liberty Rd. Randallstown, MD 21133-4784 Kellner Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medicai Examiner Examiner end I-trensit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequença ot ettending physician er for usa es the burial-I Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events Due to (or es a consequence of): resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. eup 3 Probably 4 Onknown 6 1 ☐ Yes 2 ☐ No signed b p 24b. Were eutopsy findings aveilebte prior to Completed 24a. Wes en eutopsy performed? peen completion of cause of deeth? certificata has 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No Physicien: 25. Was cese reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After t 1 Naturel or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) efter 4 Homicide Hospital within 24 hours of To the Funeral I 29a. Certifier 1 Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated. edica 2 Medical Examinar: On the basis of examinetion end/or investigetion, In my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner steted. (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature end titte ot cartille 29c. License number 8 02 00 23a) (Type, Print) me and eddress of 31. Dete tiled (Month, Dey, Yeer) 32. Registrer's Signeture State Registrar FEB28 2000 DHMH 16 Rev 6/95

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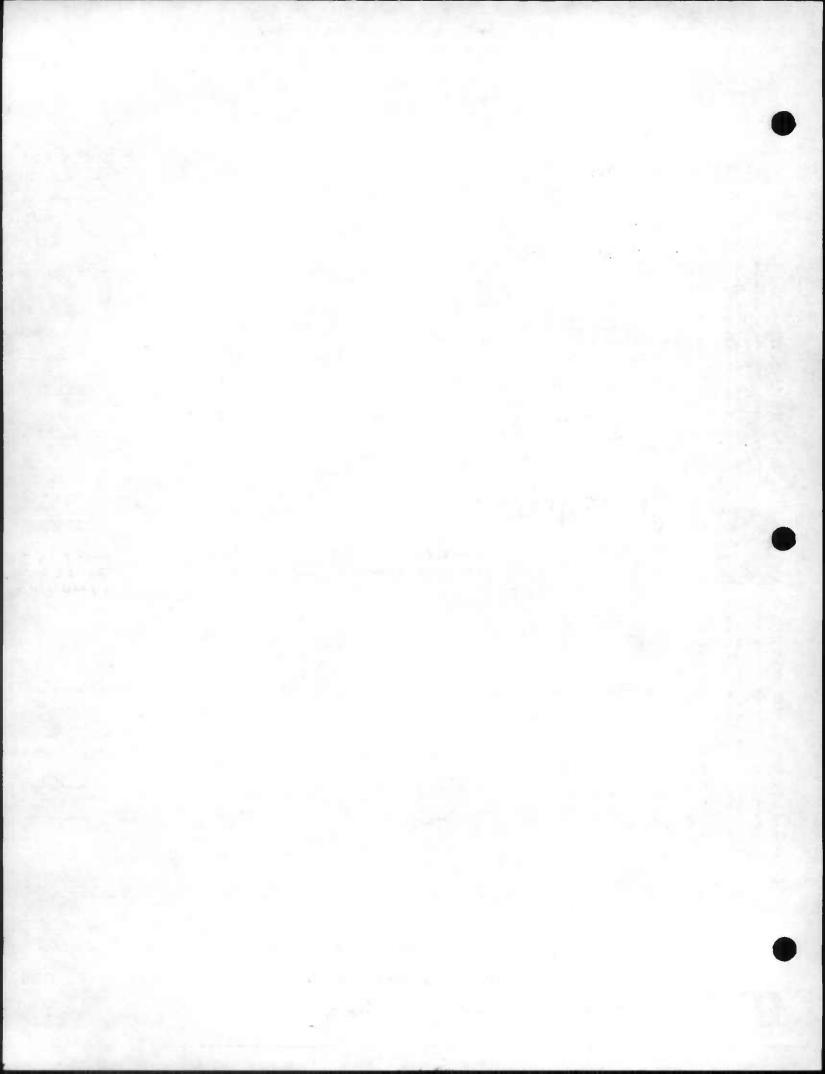
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** February 22,2000 3:45 AM Eugene Moore /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1664 Essextown Circle Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Months Yrs. 52 6299 67 Mar. 6, 1932 South Carolina Director 251 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Hestical Exercitor must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1664 Essextown Circle 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datea: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yea 2 XNo Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygie Important: if Item 27 is marked other th any Injury or other treumatic svent, the once. Foundry Worker Foundry 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earlstine Mary Wright Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Phyllis J. Moore (wife) 1664 Essextown Circle Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 MBuriel 2 ☐ Cremation 3 ☐ Removal from State 2/28/00 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Siduature of Funer 22. Name and Address of Facility
Bruzdzinski Funeral HomePA 1407 Old Eastern Avenue Essex, Maryland 21221 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final cancer disease or condition resulting in deeth) Examiner Examiner 19 MONTHS physician and the bunal-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown þ 24e. Was en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yea 2 ☑ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5 🗷 Residenca 6 □ Other (Specify) 1 Yes 2000 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital e within 24 hours a To the Funeral D 29e. Certifier edical 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45530 asaeloun MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIVASAILAM MD, 6830, HOSPITAL DRIVE, SUITE 206, BACTIMORE MD2123 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 2 8 2000

Dacks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06428 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death FEBRUARY 25, 2000 **Physician** DONALD MARK F. 11:15 A.M /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28 STRABANE COURT CARNEY BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Min. Months Hours 113M 2□ F 217-18-6661 Director 76 10/17/23 MARYLAND Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 ☑ No must be notified Director MD BALTIMORE CARNEY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s 28 STRABANE COURT 21234 USA Funeral Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 XYas 2 No If Yas, Give Year or Datas: WWII 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas % No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 about be filled will Department of Health and Mental Hygien Important; if lien 37 is marked other the any injury or other traumette of other than 2015s. 4 YEARS CREDIT MANAGER GENERAL ELECTRIC 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be SAMUEL MARK AGNES I. ALLEN 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) CONCETTA L. MARK WIFE 28 STRABANE COURT BALTIMORE, MD 21234 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) MORELAND MEMORIAL PARK 2/29/2000 HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 21286 23a Part Venter the disease, or complication in which or heart failura. List only one cause Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final Zyrs, disease or condition resulting in death) Examine Examiner attending physician and for use as the burla-transit The lew requires that the deeth certificate be assouted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes W No 3 Probably 4 Unknown Records. p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2D No 1 Yes 1 ☐ Yes 2 ☐ No cortificata Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I Be 25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes \$ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ts Certifying Physician: To the best of my knowledge, death occurred et the tima, date and place, and due to the cause(s) and manner as stated.

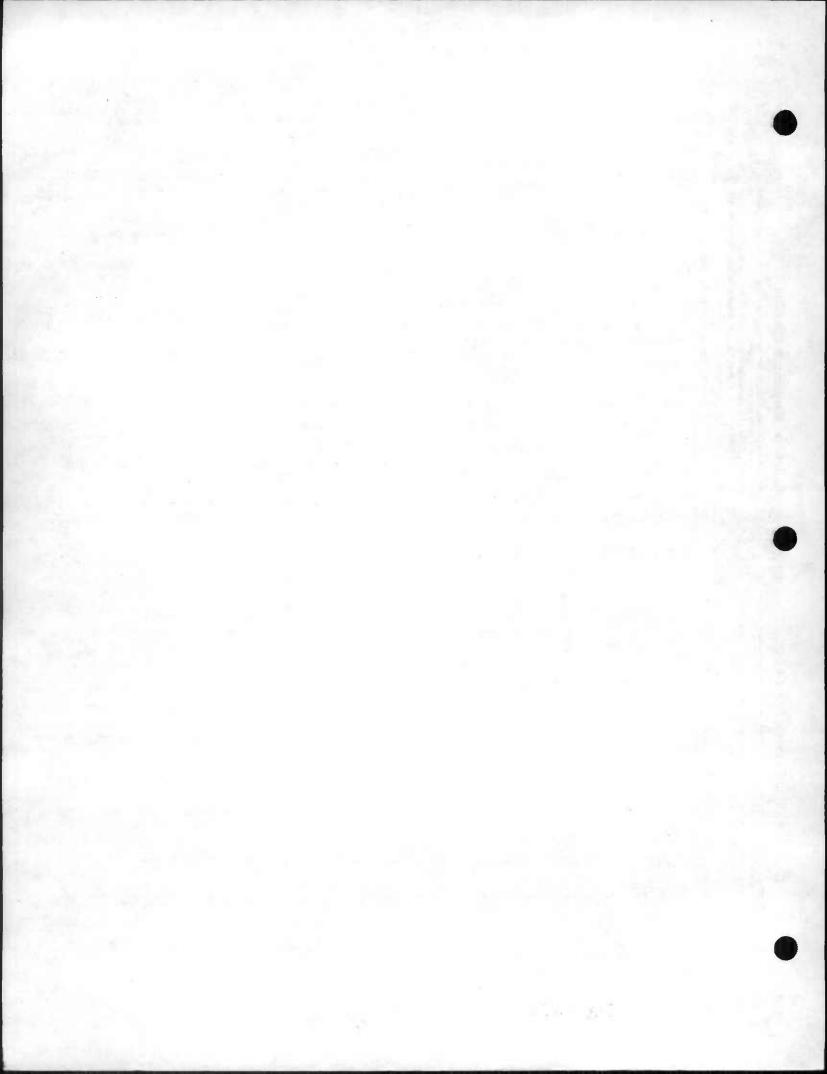
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and titla of certifier 29d. Data signed (Month, Day, Year) 016587 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud, Boltmore, MD 21239 hang., mg- 56a

State Registrar

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) FEB 2 8 2000

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent'a Nama (First, Middla, Last) 3. Time of Death 2. Date of Death Month FEB. Dey 24, 9:50pm Peter J. McElrov 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Caton Manor Nursing Home Baltimore Hunder 24 Hrs. 8. Date of Birth Hours Min. A P. 30, Year 922 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days Montha Maryland 214-18-5931 Yrs. Usual Residence of Decedent 10d. inside City Limits 10b. County 10c. City, Town or Location N/A Maryland Baltimore YE Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21234-7531 2504 Moore Avenue USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑Nas 2 ☐ No # Yas, Giva Year or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 Divorced WWIT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Baltimore City Housing Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pauline Pasterfield Peter McElrov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
538 Marlin Spike Drive Severna Park, MD 21146 19e. informent's Neme/Reletionship (Type, Print) Henry Koellein, Jr./cousin 20b. Place of Disposition (Name of cematery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramovel from State 2/25/00 Metro Crematory, Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funarel Service License Cremation Society of Maryland, Inc. male McDonald 299 Frederick Road Baltimore, MD 21228 23e. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximata intervel Between Onset and Death Immediate Cause (Final rdiac disaese or condition resulting in deeth) minutes Hypoxia Sequentially list conditiona, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Last Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Lemetoma Subdural 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

items 23s or 28s-f show the must be notified at

natural', or

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Ifem 27 is marked ofth any Infury or other traumatic event page.

death

hours after

filed within 72 al Hygiene.

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

Examiner burial-transit and that the death certificate be execu physician Physician/Medical þ Be Completed certificate edical Certification: To this

Box 68760 P.O. Records, Division of Vital Attending Physician: deeth. ne Hospital or Attendii n 24 hours after deeth. ne Funeral Director: A pletely filled in by the fo

To the F within 2 0

**DHMH 16 Rev 6/95** 

Registrar

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) MAHESH S. OCHANES 31. Data filed (Month, Dey, Year) FEB 2

gry

5 Pending

Investigation 6 Could not be determined

1 Naturel

2 Accident

4 Homicide

29b. Signeture and title of certifian rall

3 ☐ Suicide

29a. Certifier (Check only one)

32. Registrer's Signature

28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

Bartimory MA

13 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

3350

29c. License number

15204-C

Wilkers Hunne

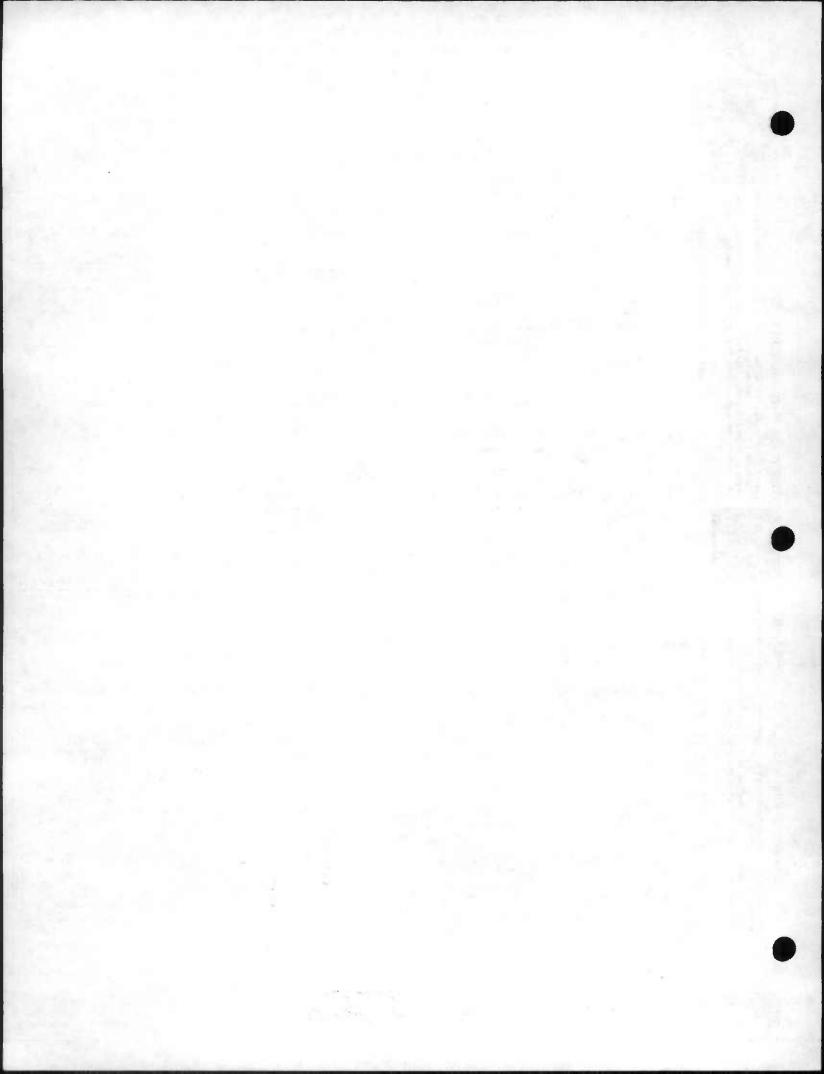
1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Data signed (Month, Dey, Year)

February 25, 2000

ite 302



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month 2 ALLEN MOXHAM 200 C

If Under 1 Yaar

10f. Zip Code

1 Yes 2 No

Head Car Inspector

22. Name and Addrass of Facility

edema

Months

Days

19702

4b. City, Town, or Location of Death

BALTIMORE

If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.)

Specify:

3. Time of Death

Birthplaca (Stata or Foreign Country)

10d. Inside City Limits

1 Yas 2 No

Delaware

4c. County of Death

10g. Citizen of What Country?

14. Raca - American Indien,

white

Black, Whita, atc.

USA

Specify:

Railroad

19701

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

Summit, Delaware

Approximeta intervel Betwe Onset and Death

1924

3,

18. Mothar's Nama (First, Middle, Maiden Sumama)

Data

2/23/00

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

BALTIMORE.

Minnie Cartridge

Physician /Medical Examiner

**Funeral** Director

the Maryland "natural", or flems 23a or 28a-f show edical Examiner must be notified at with Pages 1 and 2 should be filed within 72 hours efter with of Healith and Mental Hygiena.

Mit If em 27 is marked other than "natural", or fleaury or other traumate event, the find.

Baltimore, Maryland 21215-0020 permit. Page Department of Important: If any Injury or once. **Physician** /Medical Examiner ician and burial-transit The law requires that the death certificate be executed physician s the burial Box 68760 esn P.O. signed t Records, page 2 should Completed Division of Vital Physician: Certification: To Be this funeral After or Attending To the Hospital or Attending within 24 hours effer death.

To the Funerel Director: Afte completely filled in by the fun edical

4a Facility Nama (If not institution, give street and number) HOS DITAL OF MAKYLAND UNIVERSITY 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 1√ M 2□ F 221-12-3748 75 Usual Rasidance of Decedant 10a. State 10c. City, Town or Location 10b. County DEL New Castle Newark Director 10e. Street and Number 220 Barrett Place Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1V Yas 2 No If Yas, Giva WWII Navy Yaar or Datas WWII Navy 1 Nevar Married 2 Merried by 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middla, Last) Be (Unobtainable) Moxham 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Evan M. Moxham - son 119 Herbert Court, Bear, DE 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition XXBuriel 2 Crametion 3 Ramoyal from Stata 4 □ Donation 5 Other (Specify) Dela Vet Memorial Cemetery Funeral Service Lice Egler tha disage, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Physician/Medicai by

stenosis Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 | Yes 2 | No 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 1 🗆 Yas SKI No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) 20 No Hospital? Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas Inpatient 2 ER/Outpatient 3 DOA Data of injury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury at Work? Natural 5 Pending Invastigation 1 TYas 2 TNo 2 Accidant 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier (Check only one) 29b. Signature nd title of certifier 29c. Licensa number 29d, Date signed (Month, Day, Year) who complated causa of daath (Item 23a) (Type, Print) 30. Name and addrass of pe SOF

State Registrar Hwang

FEB28

31. Data filed (Month, Day, Year)-

22 South

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32. Registraris Signatura

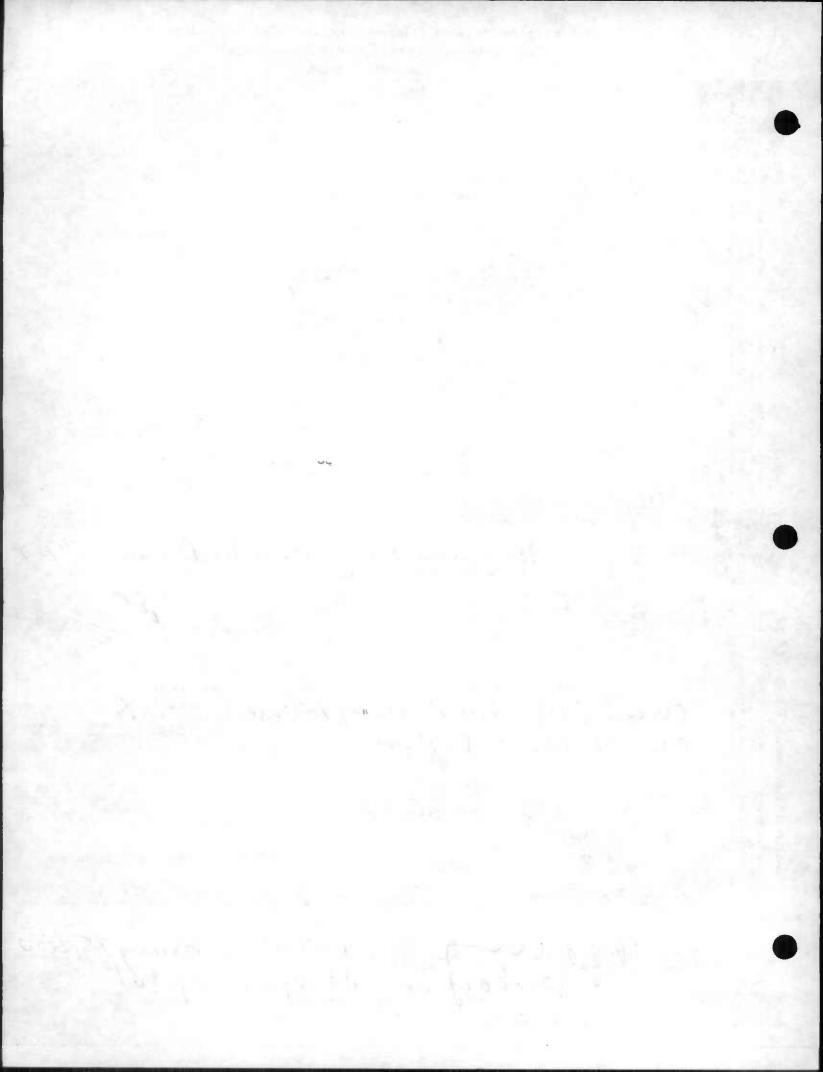
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State of Maryland / Department of Health and Mental Hygiene 00 06431

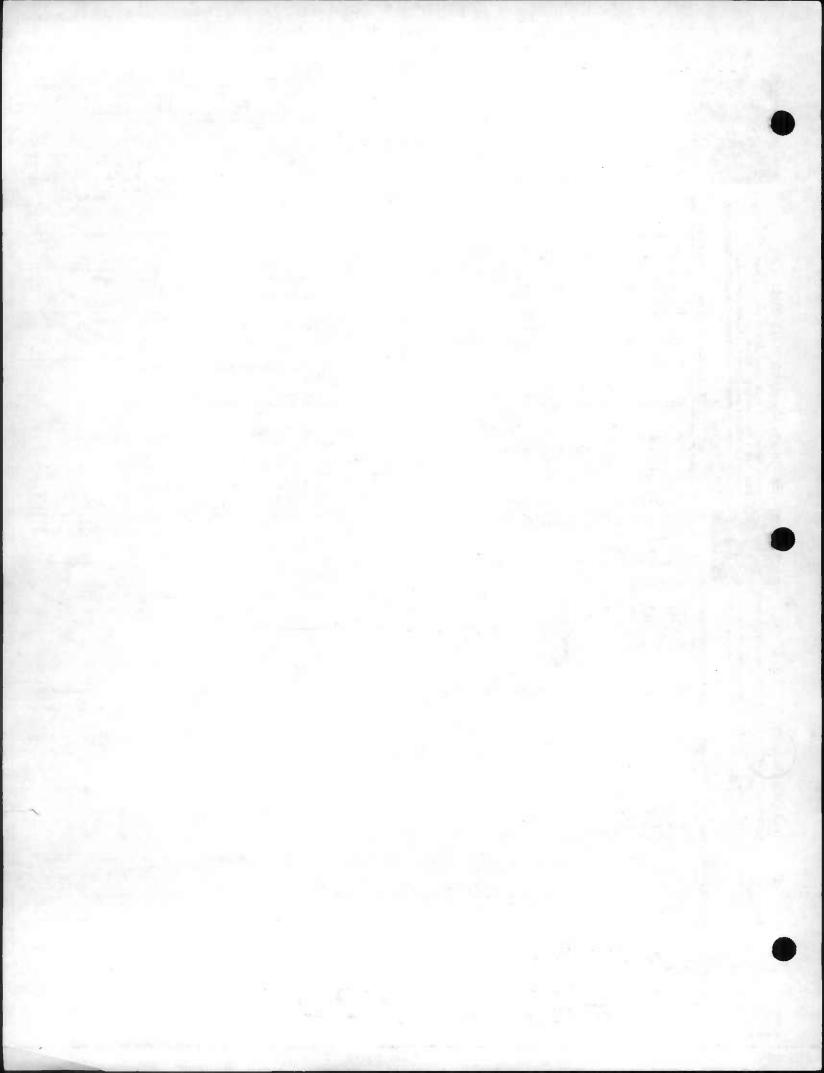
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	Physician	1. Decedent's Nam			Halle					2. Data of Deat Month	h Day	Year	3. Time of Death		
1	Physician /Medical	Edgar	J. Masten		1000					FEBRUAR		2000	0752		
	Examiner	4a Facility Nama (i			nber)					ocation of Death	4c. Cou	nty of Death			
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ı	Funeral Director	5. Social Sacurity N 221.18.13		M 2□F	7. Age (In yrs. last	Yrs.		ays Hours		8. Date of Birth Month, Day 12.21.1	923	Dela	place (State or Foreign htry) Ware		
	pue k.	Usual Residence of	10b. County		10c. City, T	own or Lo	cation					1	0d. Insida City Limits		
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	with the Mary a or 28e-f sh be notified.	10e. Street and Nu	(1 1 dg	10f. Zip Co	de		1	10g. Citizen of What Country?							
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	her death v hams 23 siner must	11. Marital Status		Armed Fo		13. \	Was Decedent f Yes, specify	of Hispanic C Cuban, Mexic	origin? (Sp an, Puarto	ecify Yes or No-		Race · Amaric Black, White,			
Maryland 21215-0020	Exar.	3 Widowed	1 Never Married 2 Married 3 Widowed 4 Divorced		f Yes 2 □ No If Yas, Give Year or Dates WWII		1 Yes 2 No Specify:				Spe	ite			
5-6	ad within 72 ho ygient. In then "natural, the Medical. Completed	(Spec	15. Decedent's E		1	(Give	dent's Usual O kind of work d	one during me	ost of work	king	16b. Kind of	f Business/Inc	dustry		
121	Phan han	Elementery/Seco	ondery (0-12)	College (1	-4or 5+)		DO NOT use r				Govern	nment			
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an	Mental H Mental H arked off attic ever	Walter M						Ka	thrvi	n (Demps	av)	· · ·			
Baltimore, Mary	SPEE	19a. Informant's N		Type, Print)		19b. Mailir	ng Address (S			ral Route Number	-	wn, Stata, Zip	Code)		
	all a	Patti Wed	ker- Dau	ghter	5	730 F	urnace	Ave.	Elkr:	idge, MD	21075	5			
	of He of He Hem	20a. Method of Dis	position  Cremation 3	ID	20b. Place	e of Dispo	sition (Name on atory or other	of				on - City or To	own, State		
	Page ment: If ury or		5 ☐ Other (Special		Balti	more/	/Washir	gton C	re.2	/27/2000	OO Laurel, MD				
	emit. Py Separtmer mportant ny injury DCs	21. Signature of Funeral Service Licensee  Gary L. Kaufman Funeral Home @ Me.											idaa Mam		
ш	20252	1/1/0	xK Ma	shall		Par	ck Inc.	/250	Washo	ongton B.	Lvd. E	Elkrido	ge,MD21075		
	Physician /Medical Examiner	23e. Part1. Ented shock, or hea Immediate Cause disease or condition resulting in death)	(Final		voscle  Due to (or as	rol	in C	2 4		culor ,		use	Approximate Interval Between Onsat and Daath		
Box 68760,	neth certificate be executed attending physician and for use as the bunal-transit slan/Medical Examiner	Cause (Disease or that Initiated events resulting in death)		b c	Due to (or as										
	the attending the for use	Part II. Other signif	lcant conditions	ontributing to de	ath but not resultin	g in the u	nderlying caus	e given in Par	t 1.	23b. Dld to	bacco use	contribute to	o the cause of death?		
P.0	igned by the a be detected to be detected to by Physic	Chron	or Ob	struce	Love Pu	· low	one	1057	eal	e 104	os 2□N	o 3 Pro	bebly 4 Unknown		
Vital Records,	The law requires that the death ce tate has been signed by the attendit page 2 should be detached for use Completed by Physician/I	()	91 11	0 (	Fal	1 1	re/			24a. Was a	n autopsy		ere autopsy tindings vailable prior to		
900	as becase of a special	Cwon	cit je	engl	rao	( )	(14)					CO	ompletion of cause death?		
2	The law page 2	ath it is								1 □ Y	s 2DIN	0 1[	□Yes 20 No		
ita	certificate rector, pag	25. Was case refer	red to medicat					26. Pla	ce of Dea	th (Check only or	e)				
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n	After the funeral fune	27. Manner of Deet 1 Natural	5 Pending		of Injury h, Day Year) 28	b. Time of Injury		Injury at Work?		28d. Describe h	ow injury oc	curred			
Division	Attending in death.  octor: After by the fune fune fileation	2 ☐ Accident 3 ☐ Suicide	Investigatio	0 00- 0	of lainer Athama	M 1 Yas 2 No							al Poida Niimhar		
)į	or A Direction by	4 Homlcide	determined	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Routa Number, City or Town, State)									arriodia ivambor,		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exam	niner: On the ba	best of my knowle	dge, deeth	occurred at t	ne time, date my opinion, d	end plece	, and due to the c rred at the time, d	ause(s) and ate and plac	I manner es s ce, and due to	stated. o the cause(s)		
	Me the	29b. Signature and	title of senifies	and man	ier stated.		29c. L	cense numbe	r	2	9d. Date sig	gned (Month,	Day, Year)		
	H 5 H 0	1	With	111	-		1	27	7/5	- 1	10 horas	(I A-A	25,2000		
	Dy.	30. Name end addr	ess of opport who	completed caus	e of death (Intern 23	la) (Type.	Print)		11)		CAAN	1	0,000		
	de	MI	Fri	deulo	eri	Mn	.8	+ N	4 ne	1 1/19	VAF &	W			
	State	31. Date filed (Mon	th, Day, Yaar)	32. R	egistrar's Sgnature		A A	oorks	1		7				
	Registrar	5 S S S S S S S S S S S S S S S S S S S	FERRO	SUMU	Depte	/	11								

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Decedent's Neme (Firs	YG780 2/28 st, Middle, Last)		-11				2. Date of De Month	Day	Year	Time of Death	
4e Facility Name (If not institution, give street and number)  4b. City, Town, or the facility Name (If not institution)								h 1 4c. County	SHUU -	)2:13 A	
1 1			. \	11						a rod	
5. Social Security Number		Mary		ast birthday)	f Under 1 Year	Bar If Under 24 Hr	s. 8. Date of Bi		O Righolaca	and the second second second second	
212-56-5000 Usuel Residence of Dece	) 1[3	(M 2□ F	48		fonths Day			sy, Year)	9. Birthplaca ( Country) Virgi	nia	
	. County		10c. City	, Town or Local	ion				side City Limits		
Md. B	Baltimor	re Essex							11	Yes 2 No	
10e. Street and Number					10f. Zip Code		10g. Citizen of \	What Country?			
15 Cool Bre	eeze Dr.							United			
11. Marital Stetus  1 ☐ Never Married 2  3 ☐ Widowed 4 ☑ D	2 Merned	2. Was Decedent Armed Forces?  1 Yes 2 Xf #Yes, Give Year or Detes:			f Hispanic Origin? ( uban, Mexican, Pue lo Specify:	Specify Yes or Norto Rican, etc.)	Specify	ck, White, etc.  White	ian,		
	Decedent's Educ			16a, Deceden	t's Usual Occ	cupation		16b. Kind of B	usiness/Industry		
(Specify only	ly highest grade	e completed) (I			d of work dor NOT use reti	ne during most of w	orking	Restau			
17. Father's Name (First,	Middle, Last)			Cook		18. Mother's Na	ame (First, Middle				
Ernest R. M						V. Spend					
19a. Informant's Name/Re		oe. Print)	1	19b. Mailing	Address (Stre	et and Number or F			State. Zin Code	)	
Ernest R. M						ze Dr. Es					
20a. Method of Disposition		LOLLIEL	20b. PI	ece of Dispositi	on (Name of		Date		City or Town, S	itete	
1 Burial 2 Crer		emovel from State		metery, cremet			1 46 00	200 5 7			
21. Signeture of Funeral S	Funeral Service Licensee    Chesapeake Crematory Feb.16,2000							000 Bel	tsville	, Md.	
21. Significant of Yorkinstat.	1			*CA	FA Ste	phen D. I	ohrmann	P.A.			
23a. Pert1. Enter the dise		desly)		87	17 Gre	en Paster	s Dr. Ba	altimore		1286	
Due to (or es a censequence of):    Due to (or es a censequence of):											
Pert II. Other significant of	conditions con	tributing to death by	it not resu	iting in the unde	oiven in Pert I	23b. Did tobecco use contribute to the cau					
		in Data ig to Couli i	ang in the unde	mying daddo		Yes 2 No	3 Probably	1			
		2						s an autopsy ormed?	evailable	ion of cause	
							10	Yes 2000	1 ☐ Yes	2 No	
25. Was case referred to	medical					26. Place of D	eath (Check only	one)			
examiner?	Н	ospital:	nt 2   1	nt 2 ER/Outpatient		Whore	Home 5 ☐ Res		ner (Specify)	-	
OT Mannes of Dooth	Dondina	28a. Date of Injur (Month, Day	y	28b. Time of Injury	28c. In		1	how injury occur			
27. Manner of Death	Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	in lary		☐Yes 2☐No					
		28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						281. Location (Street and Number or Rural Route Number, City or Town, State)			
1 Alatural 5 2 Accident	Could not be determined	building, etc									
1 Natural 5 2 Accident 3 Suicide 6 4 Hornicide	determined	ician: To the best o	examineti	vledge, deeth or on end/or inves	curred et the	time, date end plac y opinion, death occ	ce, end due to the curred at the time,	cause(s) and made, date and place,	anner as stated. and due to the o	cause(s)	
1 Natural 5 Accident 3 Suicide 6 Homicide  29a. Certifier 1 (Check only one)	determined	ician: To the best of	examineti	viedge, deeth oo on end/or inves	tigation, in m	time, date end place y opinion, death occurse number	ce, end due to the curred at the time	date and place,	anner as stated. and due to the c		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 10:30 PM miller 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUnder 24 Hrs.
Hours Min.

November 8, 1456 North Carolina

101 India City Limits If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 216-68-4886 Usual Residence of Decedent 43 M 2DF 10c. City, Town or Location 10b. County 10d. Inside City Limits timore Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Avenue 721 2121 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) trances James Thomas -ea 10 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3200 Ripple Road Bultimore, Mary kind 21244 Robinson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2-26-00 Baltimore, Maryland Name and Address of Facility Funeral Home PA 21. Signature pl-Funeral Service Licenses 38 N. Cilmar Baltimore, Maryland 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) SEPSIS Due to (or as e consequence of) ANemia severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) hatron Due to (or as a consequence of): 99 Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of death? SONO 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner ician end buriel-transit The lew requires that the death certificate be assecuted physician is the buriel Records, P.O. Box 68760, 188 M aigned by the a

Division of Vital

Attending

death.

this

Physician

Physician

/Medical

Examiner

Director

Completed by

Be

Funeral

Director

worle

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglens. Important: If Item 27 is marked other than "natural", or home 23s or 28s-f show eny Injury or other traumatic event, the Medical Example must be notified at 90ms.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ

Medical Certification: To Be Completed pege 2 a certificate funeral After To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completaly filled in by the fu

25. Was case referred to medical examiner? 1□ Yes > No 27. Manner of Death

1 Natural 2 ☐ Accident 5 Pending investigation 3 Suicide 6 ☐ Could not be 4 Homicide

28e. Dete of Injury (Month, Day Year)

28b Time of 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Baltimone

10d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year) 20000

md. 21223

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

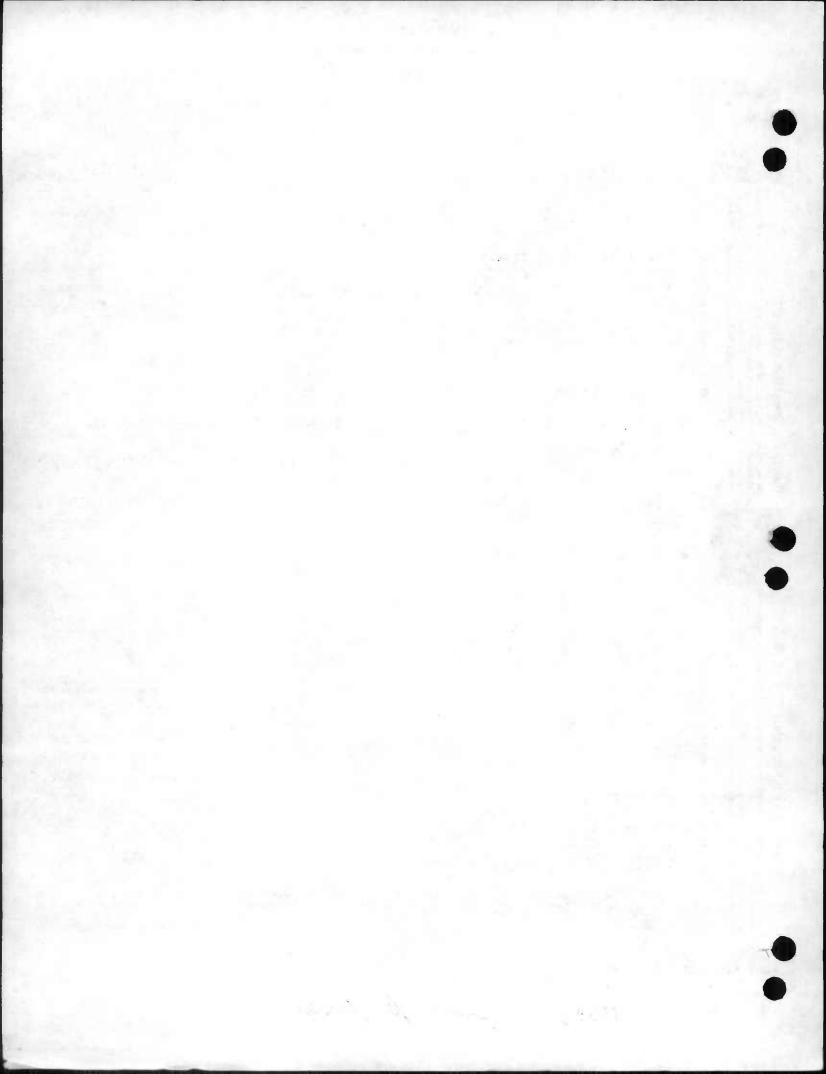
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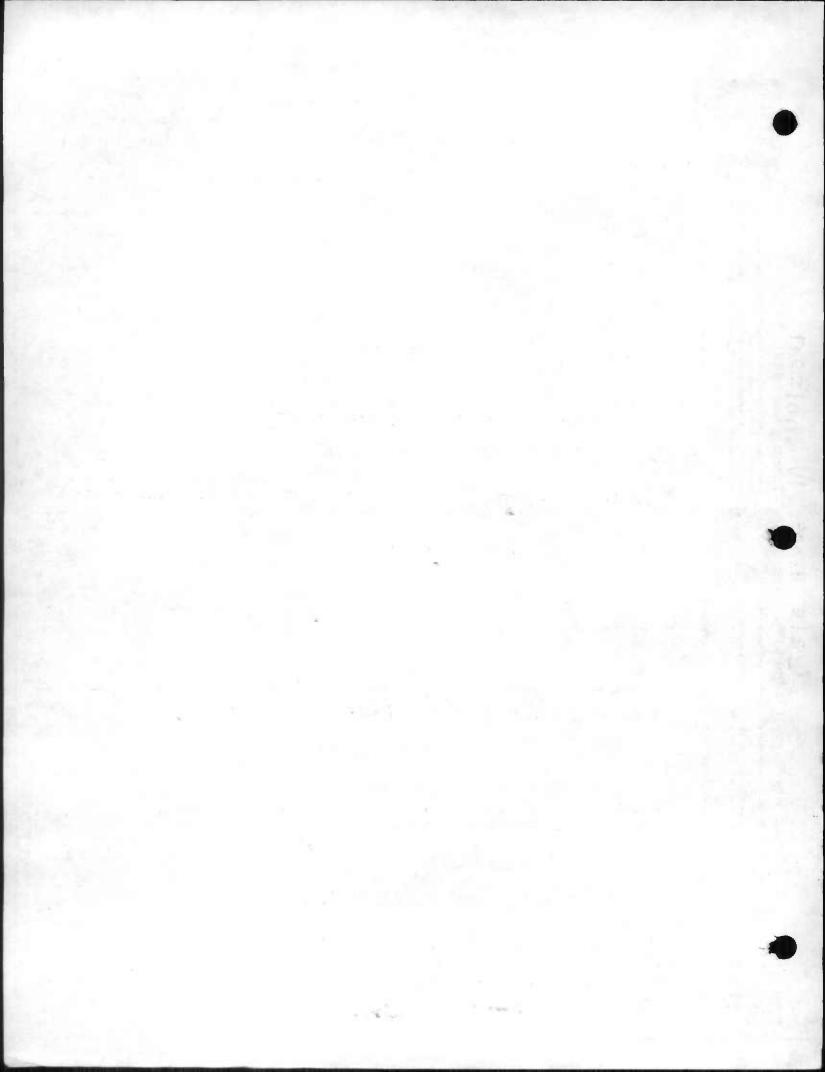
Registrar

31. Date filed (Month, Day, Year) FEB28 32. Registrer's Signeture

M.D.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10stine 10:30AM Feb 2000 26 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner trundel 4050 Arundel Arnde nne If Under 1 Yea If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 216-22-3495 Days 1 M 2 X X 78 Months Hours **Director** Sept. 25, Md Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 25a-f show notified at Md. Anne Arundel Severn 1 Yas 2000 Director 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ne 23a or mast be 782 Queenstown Road 21144 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married Maryland 21215-0020 b 1 Yes 2 Nto Specify: Specify: Black by 3 ₩ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Supervisor DC Children Center 10th Grade 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Harrison Watts Zora Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a Ellen R. Watkins Daughter 782 Queenstown Road Severn, Md. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Pages 1 Devial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Saints Rest Cemetery March 1 Harmons, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 derbe Lutter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** Pheumonia 3 Weeks Immediate Cause (Final disease or condition resulting in death) /Medicat Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last the burial-trar Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? Renal 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tailure of Vital Records, Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes an eutopsy performed? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☑ No this certificate or Attending Physician: director. Be 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No funeral 27. Manner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Division 1 Natural 5 Pending invastigation safter death. 1 Yes 2 No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide To the Hospital within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier SKian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ive Glen Burnie MD 21061 Hos 2 8 2000 62. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06435 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** William Peyton 分3 10:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2069 Larkhall Road Baltimore Balto. / MD 21222 5. Social Security Number 7 Ana (In vrs. last hirthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 18 M 2□ F Hours 32 Director 217-88-4825T Aug. 13, 1967 Maryland **Usual Residence of Decedent** 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Dundalk Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? magit be 21222 United States 2069 Larkhall Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status X☑ Never Married 2☐ Married 1 Yes 2 No Specify: Specify: White py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be the transfer of Health and Mental He tart; if hem 27 is marked oth lury or other traumatic aven Linda Gudgeon Arthur Peyton, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2069 Larkhall Road Christine Peyton (Sister) Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department or important: If any injury or Holly Hill Cemetery 2/28/2000 Middle River, Md. 21. Signature M Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Smulle the burlal-transit Due to (or es a consequence of): Completed by Physician/Medical

**Physician** /Medical Examiner

The law requires that the death certificate be execut

P.0.

Records,

Division of Vitai or Attending Physician: signed by the attending p

this certificate has

After

24 hours after death.

within 2 ş

Hospital

funaral

filled in by

completely

89

Medical Certification: To

28a-f

5

72 hours after

filed within Hygiene.

21215-0020

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a cons

23b. Did tobacco use contribute to the cause of death?

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1□ Yea ZNo 24a. Was an autopsy performed?

Yes

24b. Wera autopsy findings available prior to completion of cause of desth?

1 Yas 2 No

3 Probably 4 Unknown

25. Wes case referred to medical xaminer?

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

27. Manner of Death
1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Cartifier (Check only one) 29c. License number

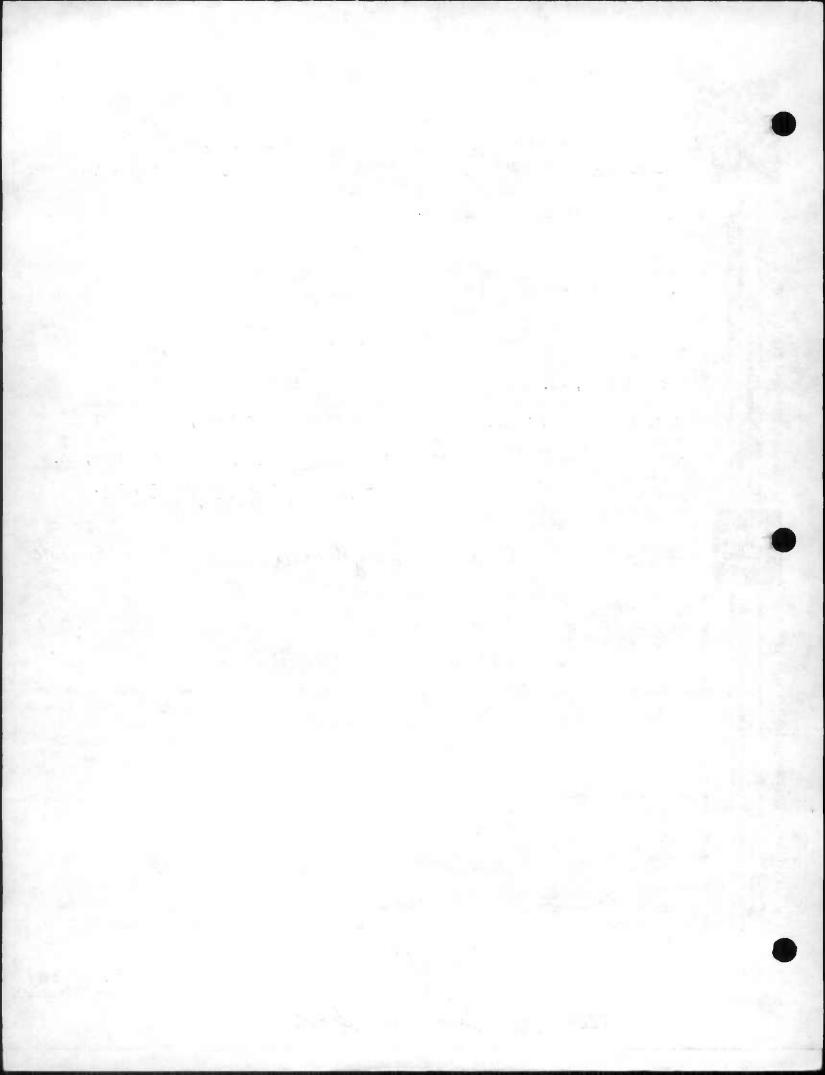
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Barrice dud 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

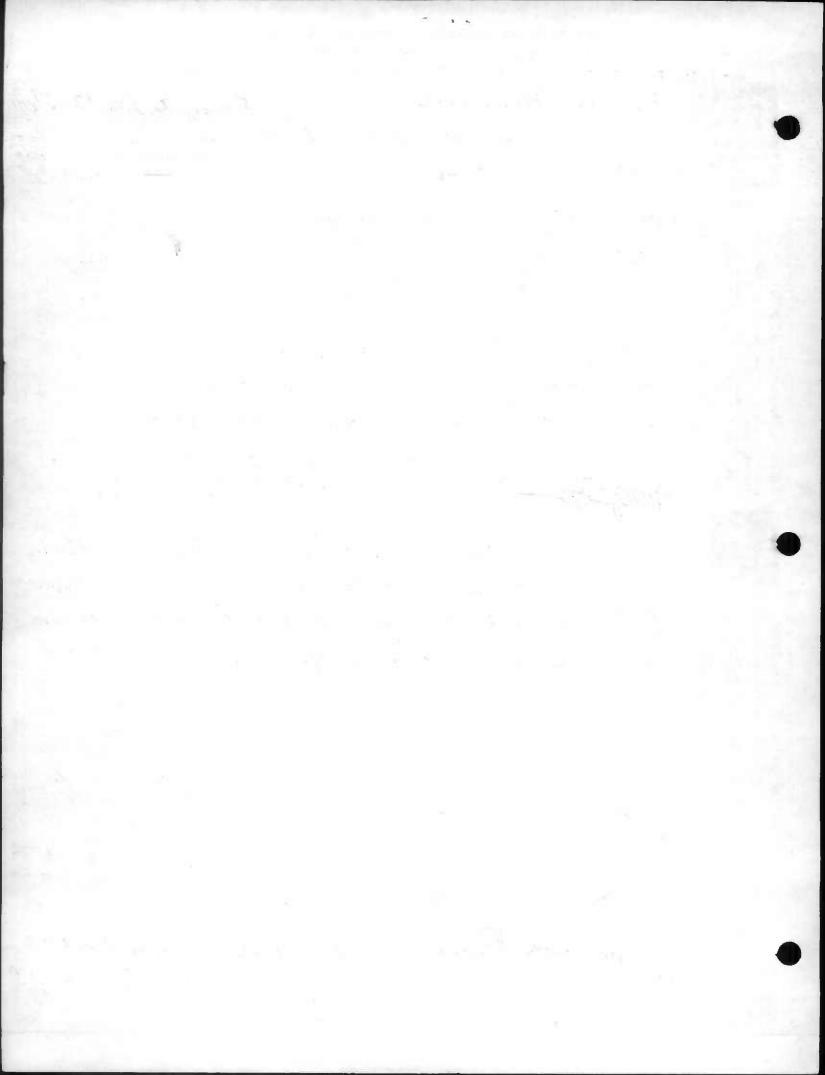


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#7.8 perFH G780 2/28/2000 EW 1. Decedant's Name (First, Middla, Last) 2. Data of Death **Physician** oseph  $\alpha rrino$ 12; /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore amaritan Hospital N/A 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 1920 **Funeral** Days 1**X** M 2□ F 209-10-6717 Director July 20, 1<del>928</del> Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsms 23s or 28s-f show traumatic svent, the Medical Examerer must be not thed at 1 Yas 2 No Directo Maryland N/A Baltimore City 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 6000 Bellona Avenue 21204 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puarto Rican, atc.) Rece - Amarican Indian, Black, White, etc. 72 hours after 1X Yes 2 No If Yas, Giva Yaar or Datas: WWII 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: þ 3 ☐ Widowad 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within: Department of Health end Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic svent, in Median Elemantary/Secondary (0-12) Collega (1-4or 5+) Hair Stylist Self Employed 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Antonio Parrino Svlvia Capuano 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Agatha Metzdorf / Niece Joppa, MD 21085 106 Duryea Drive 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data N Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Gardens of Faith Cemetery 3/4/00 Baltimore, Maryland 21. Signatura of Funaral Supplicensea Timothy Harman 22. Nama and Address of Fecility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter I/a disaasa, or complications that caused the daeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or hadar failura. List only ona causa on aach lina. Approximata Intarval Batween Onsat and Death **Physician** Immadiata Causa (Final disease or condition rasulting in daath) /Medicai Examiner Physician/Medical Examiner Lyocardial Ischemia buriel-transi Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): myocardia physician the burie Box 68760. The law requires that the death certificate be Due to (or es e consequance of): USe I P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yas 2 No Division of Vital 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1□ Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of De 28d. Dascribe how Injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Panding invastigation 24 hours after death.

Funersi Director: Aft 1 Yas 2 No 2 Accident 6 Could not be datarminad 3 Suiclda 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) à 4 Homicida 1 DcCertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian edicai To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signatura end titla of certified D38956 February 26, 2000 Scol Loch Raven 3/Vd, Baldinae Mayl addrass of person who complated causa of death (Itam 23a) (Type, Print) 32. Ragistrar's Sign State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Lucy Marie Partlow FEBRUARY 26 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SQUARE HOSPITAL GALTIMORE FRANKLIN ENTER | ROSEDALE
If Under 24 Hrs. 8. Date of B 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 200 217-34-6557 61 Director Jan. **Usual Residence of Decedent** 10a, State 10b. County 10c. City, Town or Location Md. Baltimore White Marsh Director 10a Street and Number 10f. Zin Code 10g, Citizen of What Country? or hems 23s or aminer must be 21236 USA 6 Burbage Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2℃No Specify: Baltimore, Maryland 21215-0020 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration 12th Grade Medical Claim Examiner 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant; if Nem 27 is marked off jury or other traumatic even Coy L. Johnson, Sr. Blanche E. Kea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 816 Cliffedge Road Baltimore, Md. 21208 Lenett M. Allen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery March 2 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused has during the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each first 2501 Gwynns Falls PKWY Baltimore, Md. 21216 **Physician** RESPIRATORY DISTRESS STNORDME IMMEDIATE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Enterocutaneous that initiated events resulting in death) Last Due to (or as a consequence of)

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Box 68760, P.O. Records, Division of Vital Attending Physician:

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To the Hospital of within 24 hours at To the Funeral D completely filled 1

physician and the bural-transit Physician/Medical 85 þ Completed certificata funaral director, 8 Certification: To this After a after 0s. N Director: An. hy the fv

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown CANCER UNG 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Matural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and alle of corumo

29c. License number 29d. Date signed (Month, Day, Year)

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FEBRUARY 26,2000

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3. Time of Death

10d. Inside City Limits

Approximate Intervat Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

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no completed cause of death (Item 23a) (Type, Print) 30. Name and add es of pen

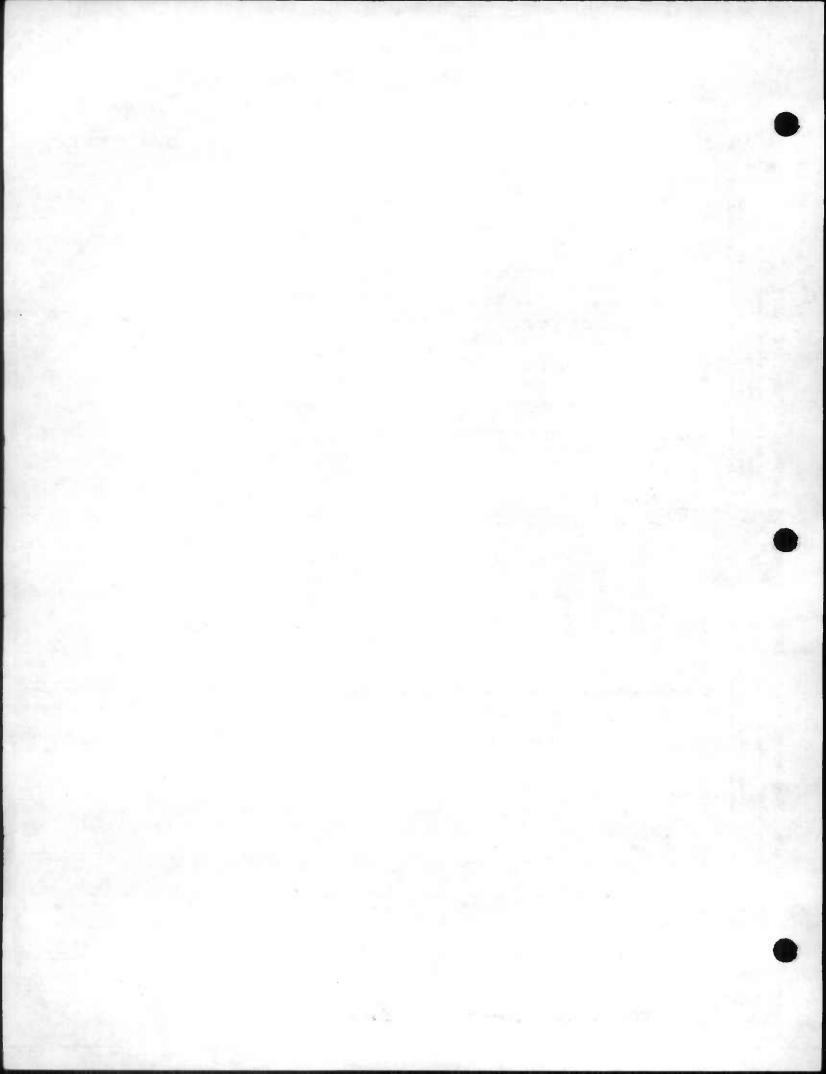
JULIE C. FRANKLIN SQUARE DRIVE BALTIMORE MARYLAND 21237 JANGULA 9000

31. Date filed (Month, Day, Year)

FEB 2 8 2000

2. Registrar's Signature

Registrar



certificata be axecuted 68760 Box P.O. Records, Division of Vital

Examiner siclen and burial-transit physiclen s the buria Physician/Medical USB BS to the signed by t by has at or Attendant.

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**Physician** 

' /Medical

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permit. Pages 1 and 2 si Department of Health an Important: if leen 27 is 1 any Injury or other traus

**Physician** 

/Medical Examiner

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Baltimore, Maryland 21215-0020

Director

Funeral

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Completed 25. Was case referred to medical Be 1□Yes 2□4No P 27. Megner of Deeth Certification: 1. Maturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 24 hours 29e. Certifier edical To the Hosp within 24 hor To the Fune completaly fi

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and Oliv of

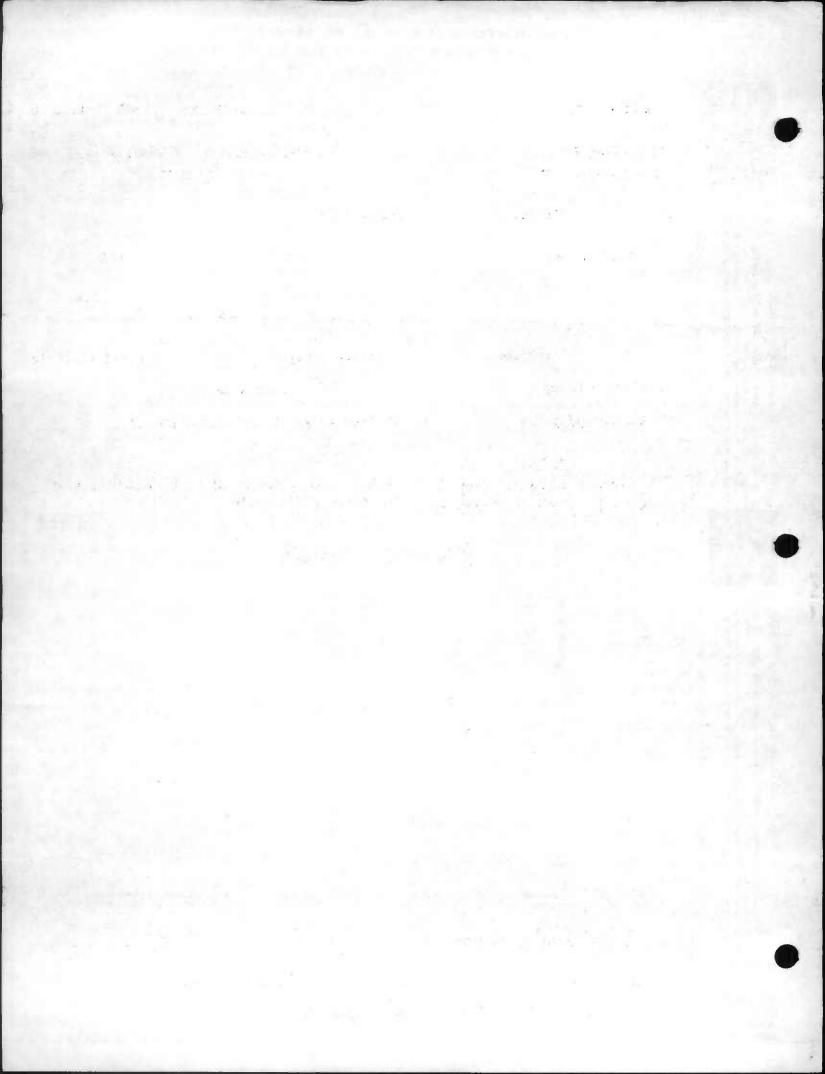
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2/17/2000

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Celans 8 AUT. MR 21264 6565 N. Charles 31. Dete filed (Month, Day, Year) FEB 2 8

State Registrar 32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Day Month **Physician** James L. Roche III 25, FEBRUARY 2000 8:25 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | H Undar 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth | 9. | Months | Days | Hours | Min. | A pril 1 0 1923 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F 216-12-5693 Vrs 76 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Exemples must be norfled at Baltimore MD. 1 ☑ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 3532 Glenmore Ave. 21206 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Merital Hydiene. Important: if flam 27 is marked other than "natural", or ker any injury or other traumatic avent, ire flam the light 1 ☑ Yas 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 WWTT 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) +7 Law Attorney 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys E. Salisbury 20 James L. Roche, Jr. 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3532 Glenmore Ave. Baltimore, MD. 21206 Mrs. Margaret Roche/Wife 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Date 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from Stete Dulaney Valley Mem Gd 2-29-00 Timonium, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21, Signeture of Funeral Service License 22. Neme end Address of Facility Ruck 1050 Towson Fu York Rd. Funeral Home, au Towson, Md. 23e. Part1. Enter the disease or complications that auged the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on leach line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical METASTATIC SMALL CELL LUNG CANCER 6 MONTHS Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be execu P.O. Box 68760, Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE Records. PV 200 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? ATRIAL FIBRILLATION 1 Yes 2 No 1 Yes ZN No Division of Vitai Hospital or Attanding Physician: 24 hours after deeth. Funeral Director: After this certifica director 25. Wes case referred to medical exeminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Netural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) NA LI 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifian 29c. License number 29d. Date signed (Month, Day, Year) mella m. 6 D41410 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

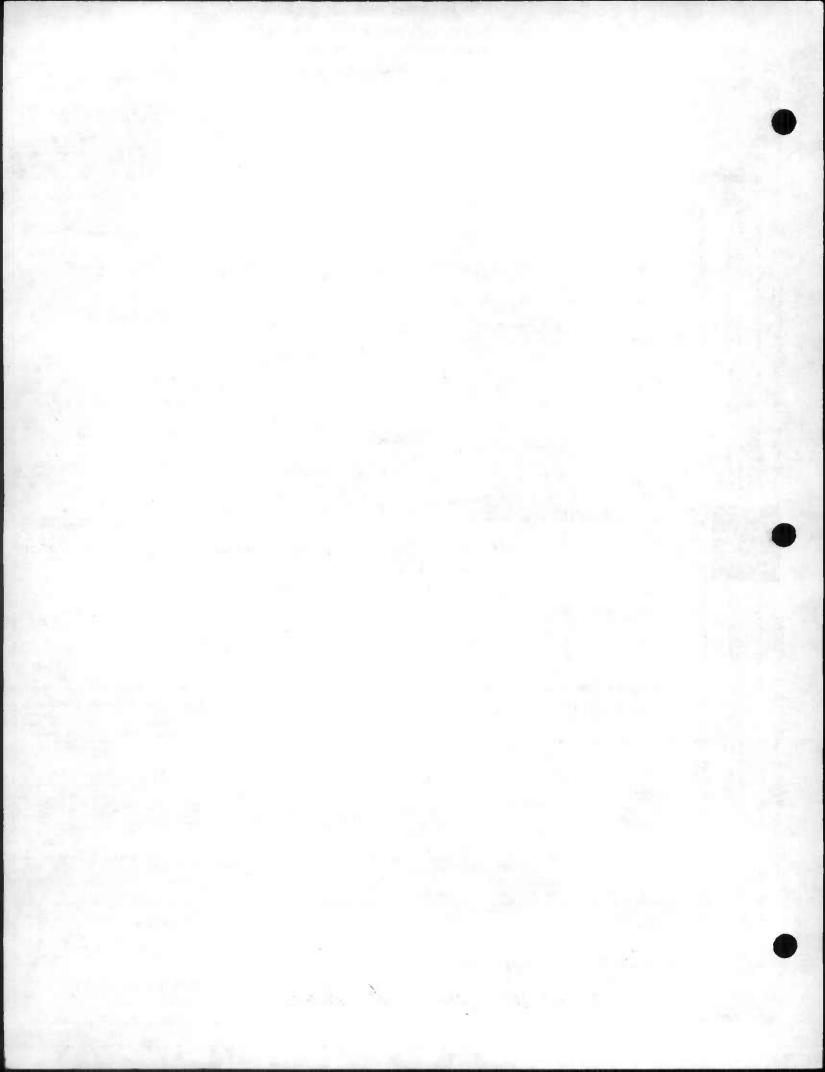
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State Registrar JOGINDER P.

31. Dete filed (Month, Day Year)

2 Registrer's Jiopenso

MEHTA M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204



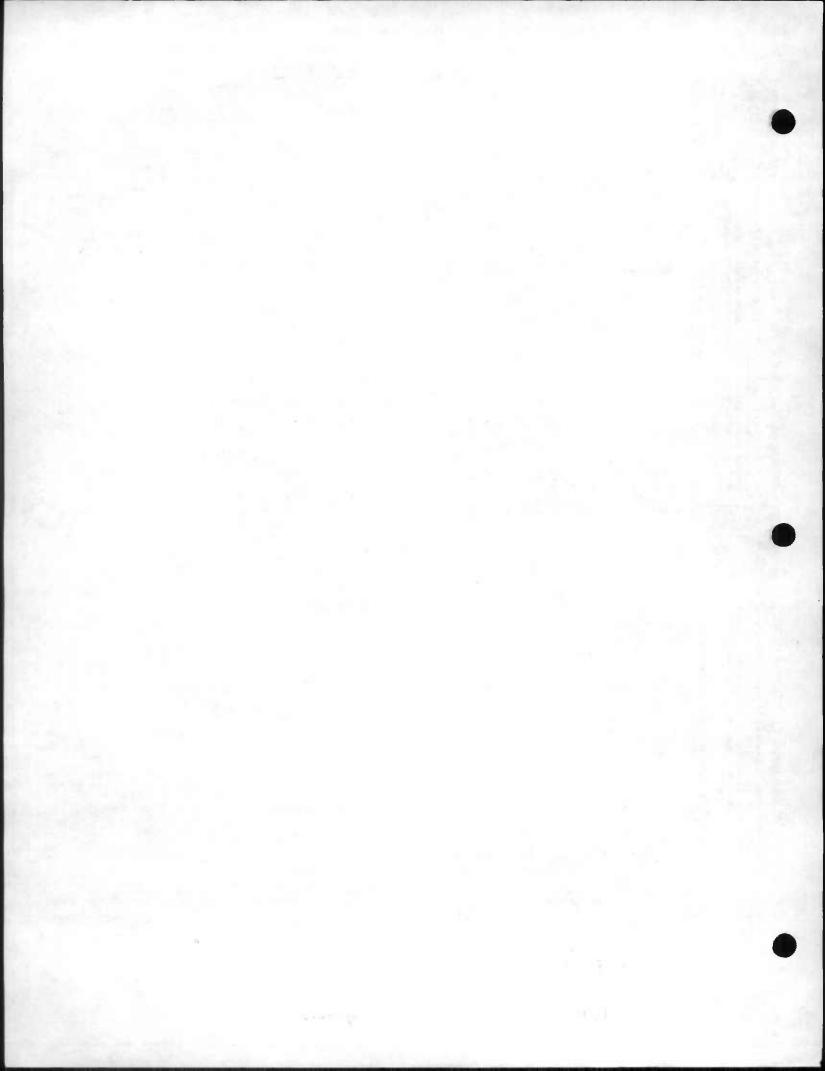
## Please Type or Print In Black Indelible ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06640 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Day Month **Physician** Frank R. Rallo February 24, 2000 9:00 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3622 Gibbons Avenue Baltimore 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days Months Hours Yrs. 217-09-2336 81 Director Oct. 15, 1918 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1X Yes 2 □ No must be notified Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or hema 23s or 3622 Gibbons Avenue 21214 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 💢 Merried 1 ☐ Yes 2 ☐XNo If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Self Employed Owner 12 Restaurant alth and Mental Hygis 27 is marked other r traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) eg e Rallo Salvatrice Giordano Louis 2 permit. Pages 1 and 2 sh. Department of Health and Important. If Item 27 is ma-any Injury or 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie A. Rallo wife ) 3622 Gibbons Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 2/28/2000 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp Alica. LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Cardio Pulmonary Arrest diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Atherosclerosis 10 years physician and s the burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) attending i 98 Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 94 2 1 ☐ Yee 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings available prior to been si 24e. Was en eutopsy performed? Completed completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. Director: After this certific Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of portif D0037280 February 25, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Jerald Insel, M.D. 5601 Loch Raven Blvd. Baltimore, Maryland 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

FEB 2 8 2000

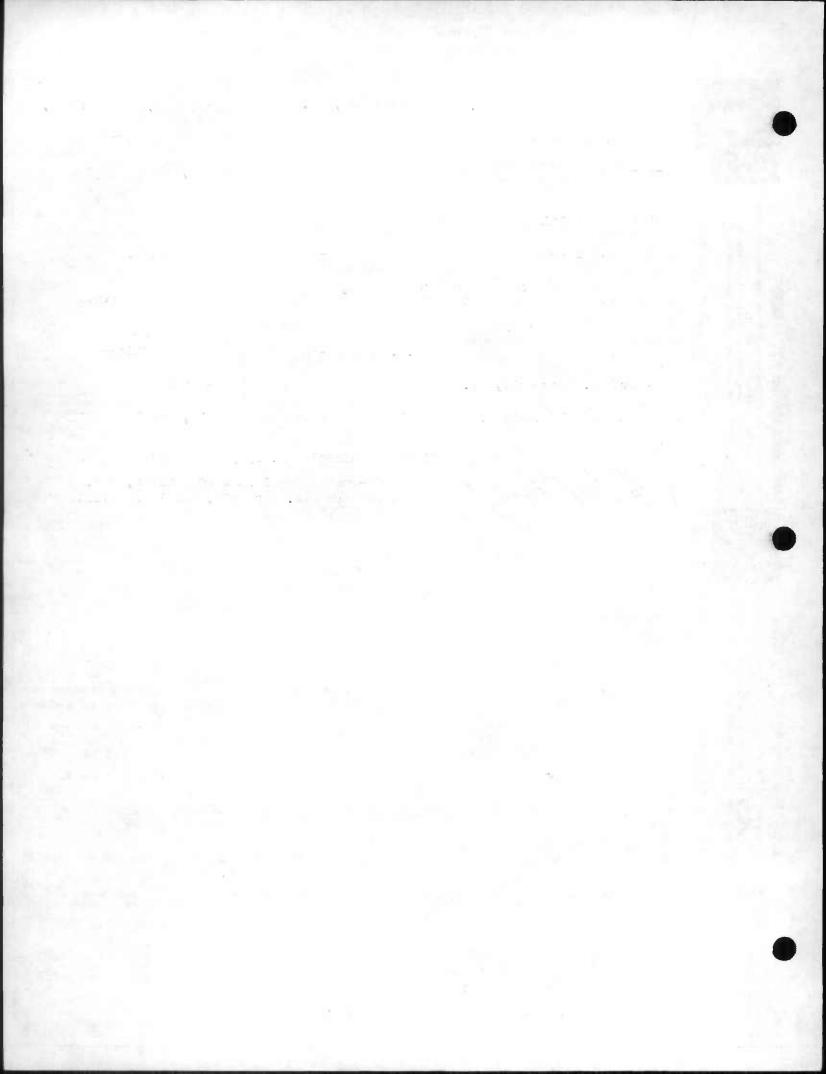


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dev Month Year **Physician** Rosendale, Jr. 8 :00 AM Joseph February 23,2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dundalk 1920 Snyder Avenue Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Days Months Hours XXM 2DF 212-34-4183 63 Director March 4,1936 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be rectined at 10d Inside City Limits 1 Yes 200No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1920 Snyder Avenue 21222 United States death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Mental Slatus 12. Wes Decedent Ever in U,S. Armed Forces? 1⊠Yes 2□No Korean If Yes, Give Yeer or Detes:Vietnam filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: Specify: p 3 Widowed 45 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Hygiene. Elementery/Secondery (0-12) 12 Years College (1-4or 5+) U.S. Government Military 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental intt: If Item 27 is marked of Dorothea Travers Joseph H. Rosendale, Sr. 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hedy Summerfield (Friend) 1920 Snyder Avenue Dundalk, Maryland 21222 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 5 Other (Specify) Arlington National Cem. 3/2/00 4 Donetion Arlington, 21. Signature of Funeral Service Lices 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Probable Sepsis

Due to (or es a consequenca of): /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown been signed by should be detac 1 Yes 2 No Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 27. Manger of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending death. 1 Yes 2 No ne Hospital or Attendi n 24 hours after death. Ne Funeral Director: A pletely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 E Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signetuge end title of certifier 29c. License number 2/23/00 00 9559 address of person who completed cause of deathy (Item 23a) (Type, Print), UNATERBURY U.J. JABAC 4940 EASTERN AUE, BALT. 21210 WATERBURY M.L 32. Registar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 6 4 4 2 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** FEB. 26,2000 2:15 Am Augusta Reason /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BELL AVENUE GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. Whole 2, 1918 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country)
MARYLAND 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F 213-20-0508 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Moorel Examiner maint be notified at RIVERSIDE 1 ☐ Yes 2 X No Director HEMET 10e. Street end Numbe 10f. Zip Code 10g. Citizan of Whet Country? 908 KEQUEL 92343 by Funeral Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bieck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 Yes 2 No If Yes, Giva Yeer or Detes: 21215-0020 1□ Yes 2XNo 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 18b. Kind of Business/Industry n end Mentel Hygiene. Is marked other than Elementary/Secondery (0-12) Collega (1-4or 5+) HOME MAKER OWN HOME Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Melden Surname) . Peges 1 end 2 should be filt ment of Heelth end Mentel Hy ant: If Item 27 is marked oth jury or other traumatic even FLECKENSTEIN WILLIAM I- . CLARA WRIGHT 19b. Mailing Address (Street end Number or Rurel Route Number, City or Jown, Stete, Zip Code) 21060 19a. Informent's Neme/Reletionship (Type, Pnint) GLEN BURNIE, MD TIGHMAN-SON 1034 A BELL AVE Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete CRM. 2 1 Buriel 2 Cremetion 3 Removel from State Depertment of Important: If any Injury or once. 2/28/00 LAUREL, MD BALTIMORE WASHINGTON 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Amerel Service Licensee 22. Name end Address of Fecility FMAN FUNERAL HOME 21075 7250 WASHINGTON BUD, EURIDGE, MD eccos 23e. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failura. List only one cause on each line. **Physician** Immedieta Cause (Finel diseese or condition resulting in daath) /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immadiete ceusa. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Physician/Medicai Due to (or es e consequence of): signed by the etter Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. P.0. 23b. Did tobacco use contributs to the cause of death? Yss 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? elrebrio vannler certificate 1 TYes 25. Was cese refarred to medicel exeminer? Be 28. Pleca of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No HOME Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 this 28a. Dete of Injury (Month, Dey Year) 27. Mapner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturel 5 Pending Investigation To the Hospital or Attendit within 24 hours efter death.

To the Funeral Director: A completely filled in by the I. death Accident 1 ☐ Yes 2 ☐ No 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 11, Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

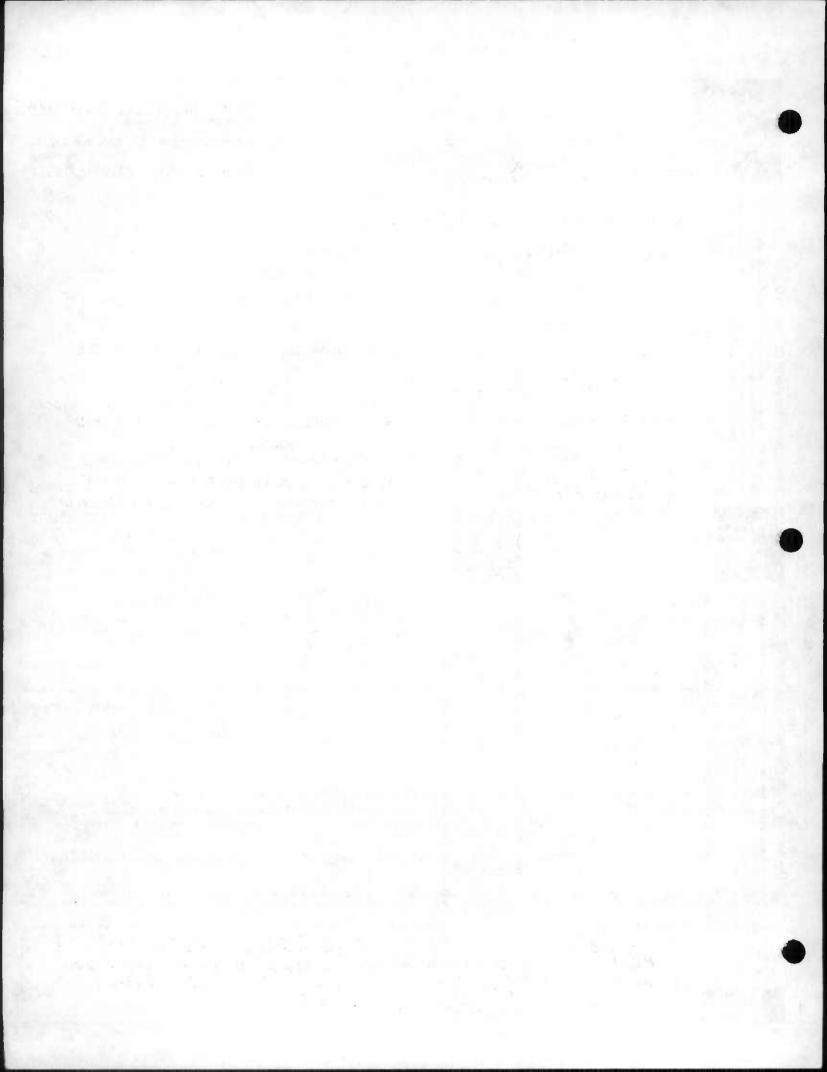
2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the ceuse(s) and mennar stated. edical 29e. Certifier (Check only one) 29b. Signature and title prertifled 29c. License number 29d. Dete signed (Month, Dey, Year) DOO 38917 28 30. Name and eddress of person who completed could of deeth (Itam 23a) (Type, Print) 1720 Crain Highway SALVAGON MIREZHD. Glen Buchie

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Yaar)

FEB28

32. Registreds Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

06443. Certificate of Death 3. Tima of Death 2. Dete of Death Feb. 24, 2000 11:25 pm

Physician	
/Medical	
Examiner	

1. Decedent's Neme (First, Middle, Last)

Director

Funeral

þ

Completed

**Funeral** Director the Mandend With

r than "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at filed within 72 hours efter deeth Hygiene. Pages 1 and 2 should be finent of Health end Mental I int: If Item 27 le marked of Item 2.

Baltlmore, Maryland 21215-0020 permit. Page Department of Important: if any injury or once. = 6 **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed physician s the burial Box 68760. Physician/Medical 80 080 signed by the e Records, P.O. þ Completed Division of Vital or Attending Physicien: Be To this funeral Certification: After death. efter death Director: 6 filled in 24 hours e Funerel ( Hospital Medical within 24 hor To the Fune completely fi 4

A. Florence Roschen 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place Baltimore If Under 24 Hrs. 5. Social Security Number 214-40-5291 8. Dete of Birth
(Month, Days Year)
Oct. 28, 1897 7. Age (In vrs. last birthday) If Under 1 Yeer 9. Birtholace (State or Foreign Months Deys 10 M 2 F Hours Maryland 102 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits City Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th St. 21211 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status Bleck, White, etc. 1 X Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Teaching 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Henry H. Roschen Louise Agnes Schroeder 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Hahn 6 Clareudon Ave. Pikesville, Md. 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 1 Cremetion 3 ☐ Removel from Stete Metro Crematory Feb. 25,2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signeture of Funnyal Service License 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nellmonta Due to (or as e consequence ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the tima, dete end place, end due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year) 251 03

1 Yes 2 No

White

Approximate Intervel Between

3 Weeks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3333 N. CALVERT ST., STE. 540, GREGOR KER

31. Date filed (Month, Day, Year) FEB 2 8

32. Registrer's Signature

Registrar **DHMH 16 Rev 6/95** 

State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** RAYMOND ROSSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 15:30 PM 4a Facility Nama (If not institution, giva street and number) Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE Note of Birth Hours Min. Juffsphr-Pay. Year 49 MONTGOMERY If Under 1 Year Months Days Birthplaca (Stata or Foreign UNIKHOWN 7. Age (In yrs. last birthday)
50 vrs. **Funeral** Hours 1⊠M 2□ F Director unknown Usual Rasidence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits unknown unknown unknown UPK PROSPINO Director m 23s or 28s-f 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral USA 14. Race - American Indian, unknown unknown 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status unknown Pages 1 and 2 should be filed within 72 hours attact over 10 Health and Mental Hygiens.

Int. If them 27 is restricted other than "natural", or the ray of other traumatic event, the Medical Examining ray or other traumatic event, the Medical Examining. 1 Never Married 2 Married 1 Yas 2 Ne If Yas, Giva UNKNOWN Year or Datas: 21215-0020 1 Yas 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown Saltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be unknown unknown 19a. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Shady Grove Hospital 9901 Medical Center Drive Rockville, MD 208 20815 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata 4 □ Donation 5 NOther (Specify) in state 21. Signature of Fuharal Sarvice Licensee
Ronald S. Wade, Director 22. Nama and Addrass of Facility State Anatomy Board 655 W. Baltimore Street 23a. Pair 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical tmmediata Causa (Finat disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue P.O. Box 68760, Physician/Medical the Dua to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contributs to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown fail ure Division of Vital Records, by 24b. Wara autopsy findings available prior to Completed 24a. Was an autoosy Cimhosis Liver completion of cause of death? Organic certificate 1 Yes 2 No 1 □ Yas 2 □ No or Attending Physician: 25. Was casa ratefund to medical axaminer? funeral director. Be 26. Place of Death (Check only ona) Hospital: 1 (Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 (MNatural 5 Pending invastigation ne Hospital or Attending n 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of trijury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) completely within 2 To the \$ 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number 0 Gan D46398 30. Nama and addrass of person who mpleted cause of death (Item 23a) (Type\_Print) lane # 409, Rockelle, mg 20852 congressional 1121 Gaupta ,MD 31. Data filed (Month, Day, Year) FEB 2 8 32. Regional r's Signatura State 2000 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 13 . 33 DIANE W. SPEARMAN FEBRUARY 25,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE ar | If Under 24 Hrs. If Under 1 Yes 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Davs Hours 10 M 20 F 218-82-1733 24 MO Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IJSA HUNTINGDON 21211 AVENUE 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EAUTH CARE 12 TH GRADE DIALYSIS TECHNICIAN YR 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) WILLS JAMES MATHEWS UCILLE 19b. Mailing, Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SPEARMAN HUSBAND 2901 HUNTINGDON Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State BALTO. MO 4 □ Donation 5 □ Other (Specify) ARBUTUS CEMETERY 03.02.00 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO. MO. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Distress Respiratory month one months ciency SIX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): THREE YEARS HUMAN IMMUNODE FILLENLY VIRUS Due to (or as a consequence of): PNEUMOLYSTIS one month PNEUMONIA Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? I Yes 2 No 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

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MD

Directo

by Funeral

Completed

Funerat

Director

Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland nent of Health and Mental Hyglena.
Int: If Hem 27 is marked other than "natural", or hems 23s or 28s-f ahow

Maryland

Baitimore,

treumetic avent, the Medical Exeminer must be notified at

other

6 permit. Page Department of Important: If eny Injury or page.

> ettending physicien and for use as the burial-transit this certificate has funeral director. After t

The law requires that the death certificate be executed

Box 68760,

of Vital Records, P.O.

Physician/Medical Examiner

2 Completed Certification: To Be

s after death.
I Director: After in by the funer Division filled in by To the Hospital of within 24 hours at To the Funeral Discompletely filled in Medicai State

Registrar

Pancreatiti 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

29c. License number AT 2438946 29d. Date signed (Month, Dey, Year) 25,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMATHA R. SADDA UNION MEMORIAL

201E HOSPITAL, BALTIMORE

26. Place of Deeth (Check only one)

. UNIVERSITY PARKWAY,

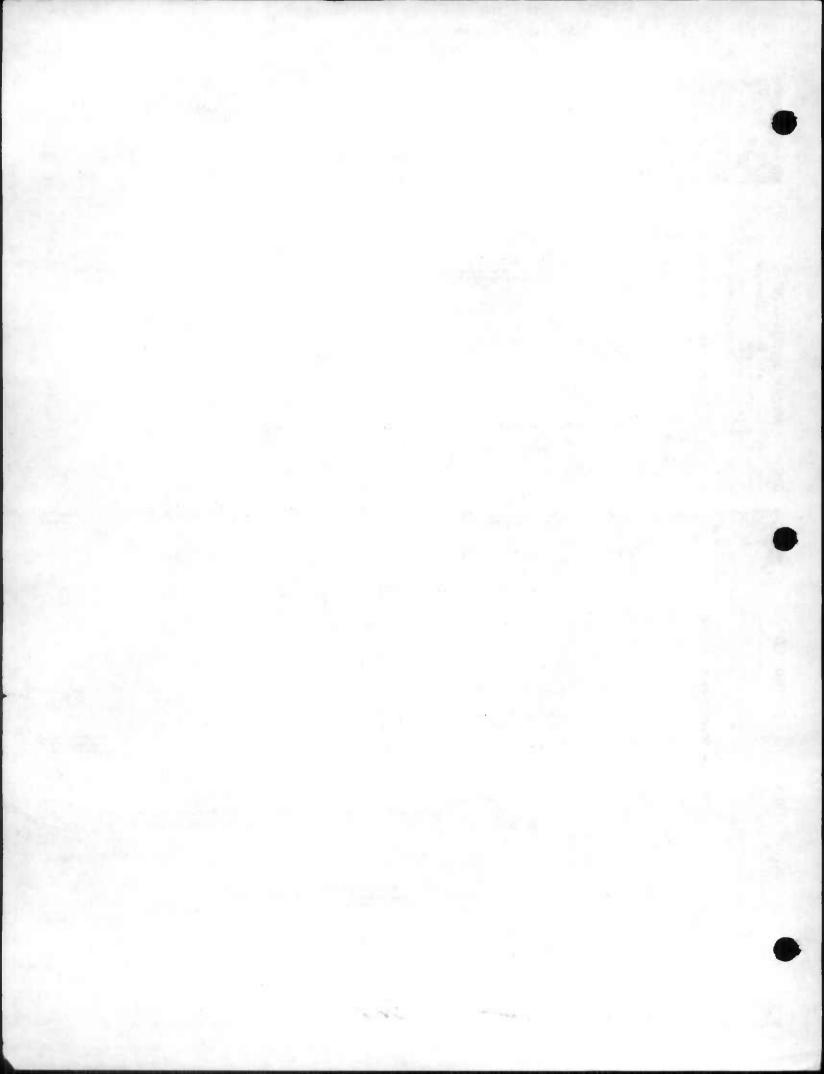
31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 2 8 2000

32. Registrar's Signature

a dde



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

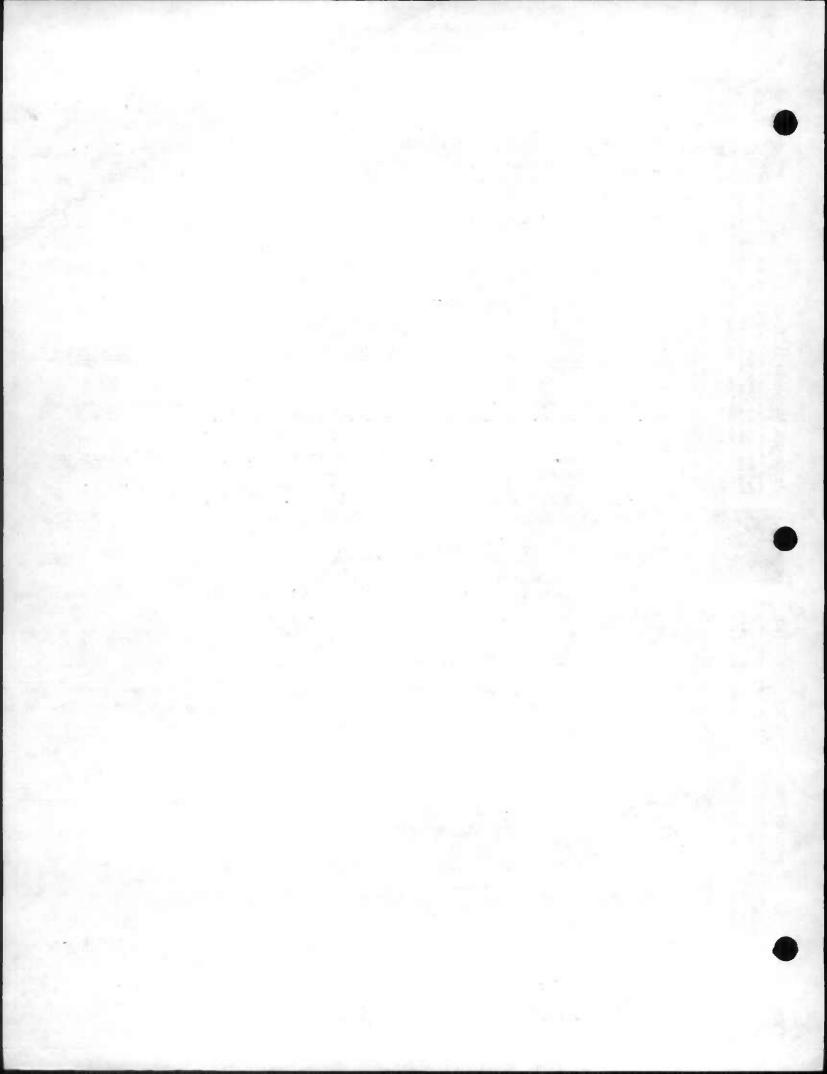
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 EBRUAYE /Medical e street arid number 4b, City Libcation of Death 4c. County of Death Examiner TMORK 8. Date of Birth (Month, Day, Year) June 18,1929 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days KXM 2□F 70 215-24-3628 Director Maryland Usual Residence of Decedent 10a. Stata 10b County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes ¾ No Directo 28a-f Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 1926 Church Road 21222 23a United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be Illed within 72 hours after nent of Heslih and Mental Hygiene. Maryes 2 No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Police Officer Law Enforcement 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Innocenzo Santivasci Angelina Schiliro (Wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Henrietta J. Santivasci 1926 Church Road Dundalk, Maryland 21222 of Health of Mem 27 lb 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cemetery 2/25/00 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fagoral Service Licensee 22 Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. PartT. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lin. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Box 68760. Physician/Medical the USB BS signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably Whiknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificata has 1 Yas ZINO 1 ☐ Yas 2 ☐ No Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To Delinpatient 2 ER/Outpatient 3 DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 Yas 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier complately (Check only one) \$ 29c. License number 29d Data signed (Month, Day, Year) 29b. Signature and titla of certifier 10 165-000 ajof death (from 23a) (Type/Print)

State Registrar

**DHMH 16 Rav 6/95** 

32. Registrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06647 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month FEB. 25, 2000 John Emmitt Sevbold 8:50pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Frederick Villa Nursing Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) SEPT 6, 1914 If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 1√2 M 2□ F Yrs. 212-05-6914 85 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Arbutus 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 22 Colony Hill Apt. 2B 21227 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James I. Seybold Wilhelmina Zell 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Mildred R. Seybold /wife 22 Colony Hill Apt. 2B Arbutus, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 2/26/00 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 21. Signefure of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that Initieted events resulting in death) Last Dua to (or as e consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? CL. April Lbrillelian 1 Yes 2 No 3 Probably 4 defiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

physician and the burial-transit Box 68760. Physician/Medical P.O. signed by the Records, Completed Division of Vitai e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica letaly filled in by the funeral director. p. Be Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

MD

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death

72 hours after

al Hygiene.

permit. Peges 1 and 2 should be file Department of Heelth end Mental Hy Important: If Item 27 Is marked oths any injury or other traumatic avent pages.

Physician

/Medical

Examiner

Examiner

by

altimore, Maryland 21215-0020

25. Was casa raferred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Neturel 5 Pending

2 Accident

3 ☐ Suicide 4 Homicide 28a. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury of Work? 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At homa, ferm, sfreef, fectory, office building, atc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner stated.

(Check only one)

6 ☐ Could not be

29c. License number 236942 My

29d. Defa signed (Month, Day, Year) 00

of person who completed cause of death (Item 23a) (Type, Print) MD

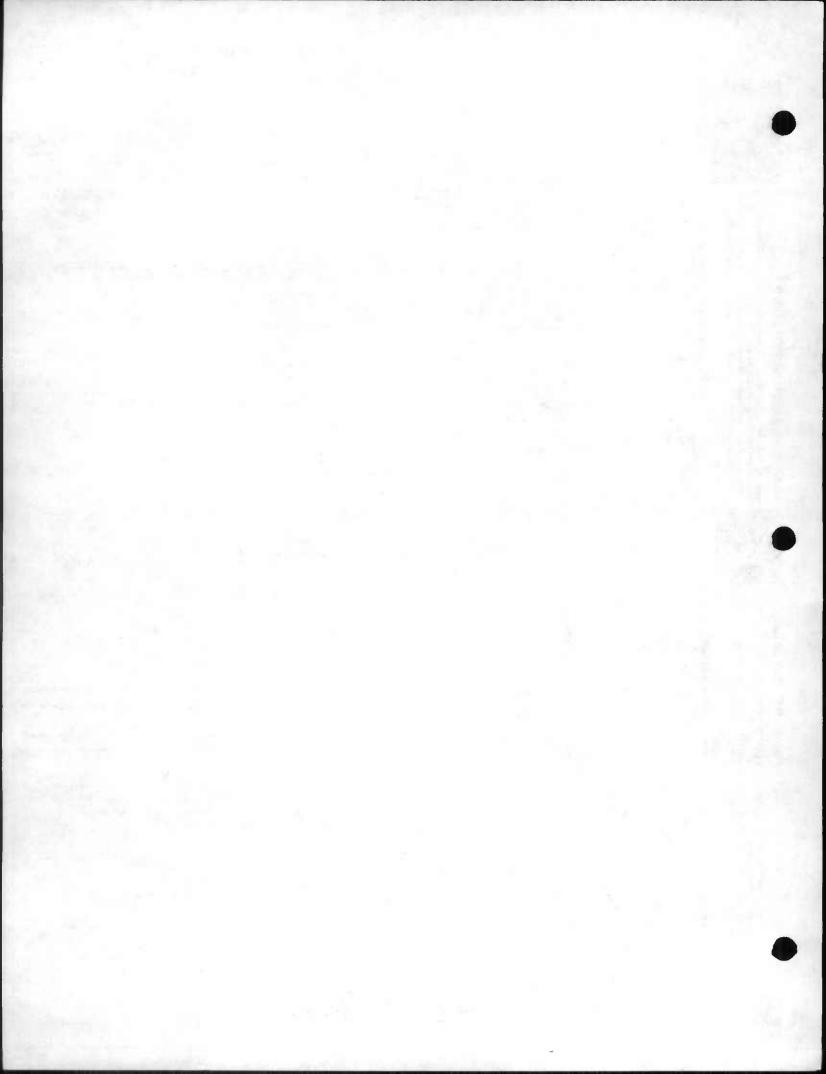
1009 Frederick Rd. Cotonsville, my

Registrar

To the Hosp within 24 hor To the Fune completaly fi

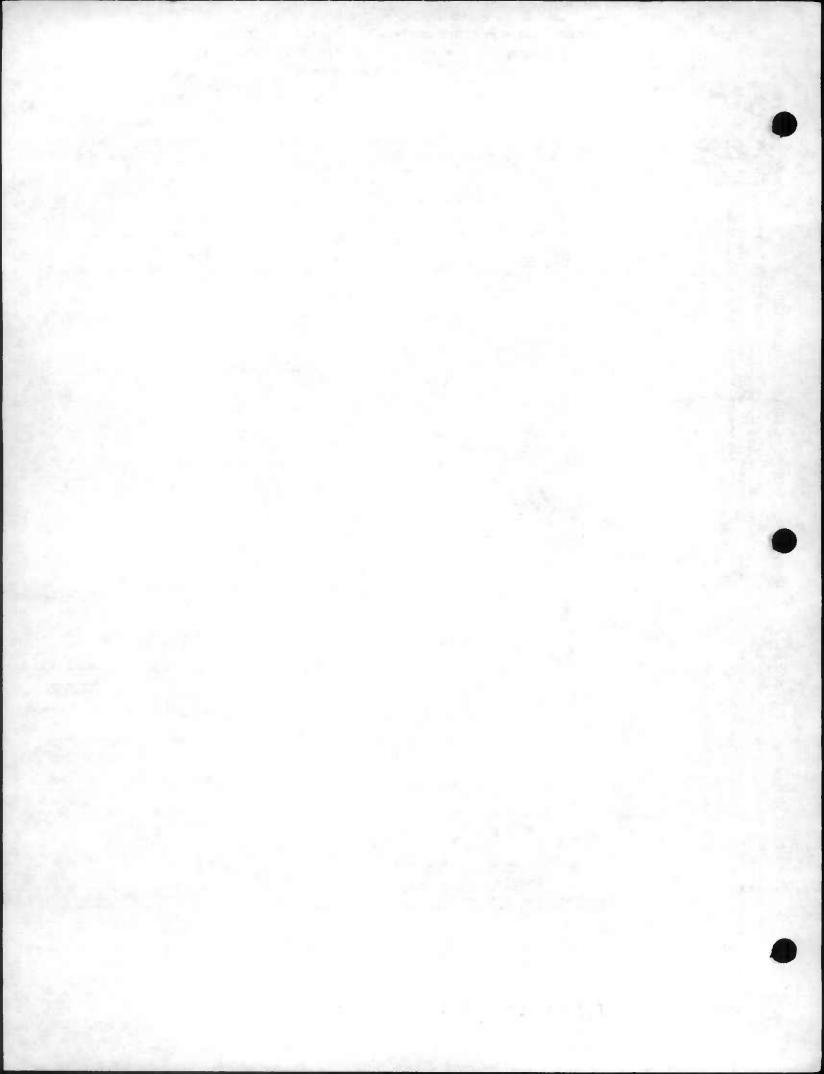
DHMH 16 Rav 6/95

31. Dete filed (Month, Dey, Year) FEB 2 8 2000 32. Register's Signeture



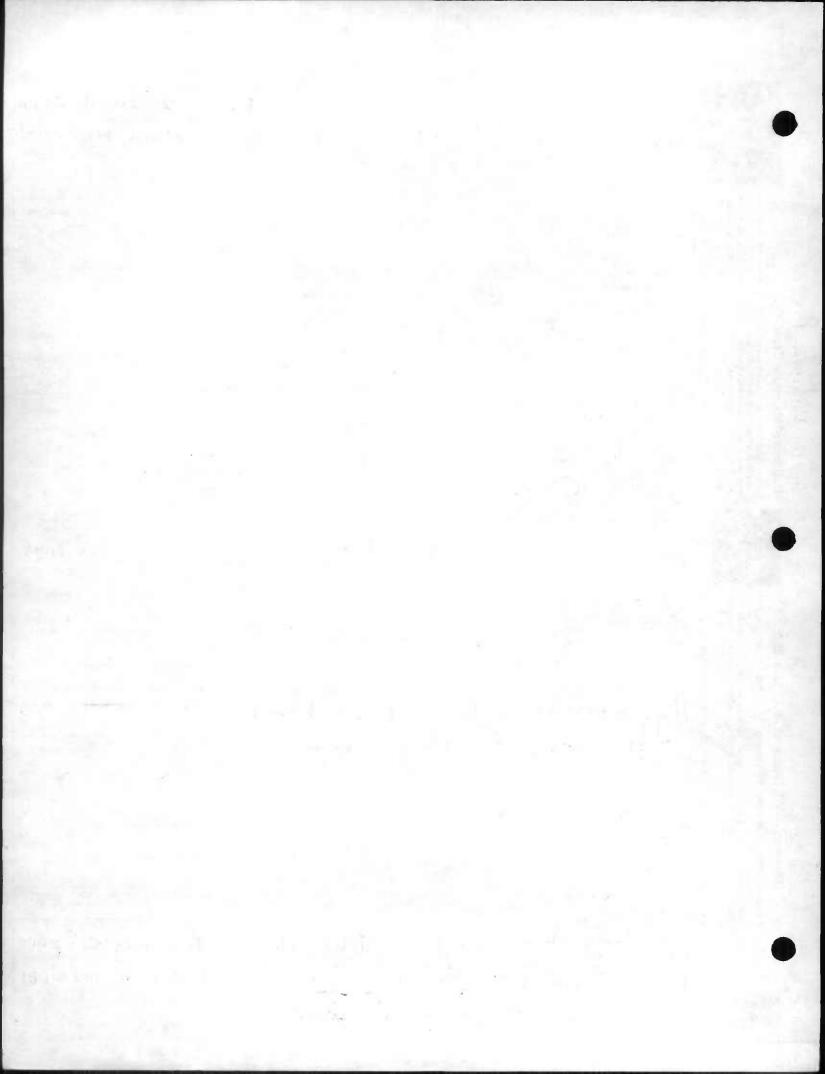
# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate of	Dealli	R	eg. No.	00440
ian	1. Decedent's Name (First, Middle, L	_ast)		CLIA	13 0	2. Date of Dee	Day Ye	
cal _	GREGORY STATE FEBRUARY 21, 2006						2000 5:10	
ner	4a Facility Name (If not institution, g			0.4	4b. City, Town, or Lo		4c. County of [	Death
		PKINS HE			BALTIP		NA	
	218-58-5921	Sex 7. Age (In № 2 F 46	yrs. last birthday Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day) 08-15-	Year)	Birthpleca (State or For Country) MD
-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or I	Location				10d. Inside City Lir
	MD NA		Baltimo					1 ☑ Yes 2 □
Directo	10e. Street and Number		Daitimo	10f. Zip Code		1	0g. Citizen of Wha	t Country?
rai Dir	910 N. Kenwood Avenue			21205			USA	
DA LO	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Evel Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13	. Was Decedent of If Yes, specify Cut	Hispenic Origin? (Special, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indien, White, etc. Black
-	15. Decedent's		16a. Dec	edent's Usual Occu	pation		16b. Kind of Busin	
nonoidino	(Specify only highest grade completed)  (Give kind of work done during multiple by the complete of the complet			Eastern Stainle		Stainles		
	12th Grade	NA	Cra	ain Oper	ator		Steel C	ompany
90	17. Father's Neme (First, Middle, Las	st)	10 M	market also	18. Mother's Name	(First, Middle, I	Maiden Sumeme)	
0	Thomas N	. Sharp			Eva	M. F	airley	
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mei	iling Address (Stree	t and Number or Rura	I Route Number	, City or Town, Ste	te, Zip Code) 212(
	Eva M. Sha	rp	910	N. Ken	wood Ave	nue Ba	ltimore	,Maryland
	20a. Method of Disposition		Ob. Placa of Dist	position (Name of ematory or other pla			20c. Location - City	
	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State				02 20	2000 p	M1
-	21. Signature of Funeral Service Lic							andallst
	- June	Court			ch FH 11			and 2120
	23a. Per 1. Enter the diseese, or co	mplications that caused the	death. Do not e	nter the mode of dy	ing, such as cardiac o	r respiratory err	est,	Approximate Intervel Betwee
	23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each firm							Onset and Deel
	Immediate Cause (Fine)						C. Allento	
	Immediate Cause (Fine) disease or condition resulting in deeth)  Due to (or as a consequence of):						UNICHO	
5			and the second second		1000			2751
Examiner		0.	to (or as a cons	CARCIA	10115			2 (1-1)
Legical	If any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last  Due to (or es e consequence of):							
Thy sicial of	Pert II. Other eignificant conditions	contributing to death but no	ot resulting in the	underlying cause g	iven in Part I.	23b. Did tobacco use contribute to the cause of		
						1 🗆 Y	Probably 4 Unk	
-						04- 144		4b. Were autopsy findi
					n raidy)	24a. Was e perfor		eveileble prior to
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Completed	25. Was case referred to medical				26. Place of Death	perfor	es 2 No	eveileble prior to completion of caus of deeth?
Be Completed	examiner?	Hospitel: 1 Minpatient	2∏ER/Outpeti	ent 3FI DOA	26. Place of Death	perfor	es 2 No	eveileble prior to completion of caus of deeth?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16619 AMENDED ITEM #23b PER MD G782 4/7/2000 AH Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 2000 10:04 Pm VIRGINIA MAY SMITH FRbrucky /Medical 4a Facility Name (If not Institution, giva street and nymber 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde) btov Norto 15mme HY UNCH (Jun If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1 M 2 DAF Months Hours 226.20.4966 74 Director 10/06/1925 VIRGINIA Usual Rasidance of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 7 No Director ANNE ARUNDEL GLEN BURNIE 288-4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 717 HAMLEN ROAD 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Btack, White, etc. Yes ZXNo 1 Nevar Married XIX Married 8 1 Yes No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottega (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ORA O. WICKS ANNIE L. PERRY 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SIDNEY A. SMITH, JR HUSBAND 717 HAMLEN ROAD, GLEN BURNIE, MD 21061 Baltimore, 20b. Ptace of Disposition (Name of cametery, cremetory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, Stata 8 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removat from State 4 Donation 5 Other (Specify) 02/25/00 GLEN BURNIE, MD GLEN HAVEN MEM. PARK 21. Signatura 22. Name and Address of Facility FINK FUNERAL HOME, PA et Funeral Service & Gusous 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 KELLY CREGORY FINK 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and it is not in heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) TEM DAYS Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): and Box 68760, Physician/Medical Dua to (or as a consequenca of): USB 85 peen signed by the attending i should be detached for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2√No Sperrobably 4 Unknown Division of Vital Records, Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy parformed? complation of cause of death? 25 No certificate 2 NO 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatienf 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation Attending 1 SNaturet Hospital or Attending n 24 hours after death. he Funeral Director: Aftr pletely filled in by the fur 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) Glun 01 MI 21061 013 -0 31. Date fited (Month, Day, Year) 32. Registrar State 3 8 5000 Denew Registrar **DHMH 16 Rev 6/95** 

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month Year **Physician** Clarence J. Thompson 1:55 P.M. February 24 2000 /Medical 4e Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rose BAITIMORE CenTer SQUARE HOSDILAI FRANKlin dAle 8. Date of Birth (Month, Day, Year) 23, 1937 If Undar 24 Hrs. (In yrs. last birthday) 62 Yrs. If Under 1 Yaar 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** Months Days Min. Hours 1 M 2 □ F 213-34-5993 Director Sept. Virginia Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2000 Baltimore 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Herne 23s or 21219 7312 Geise Avenue United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. 1 ☐ Nevar Married 2 ☑ Married natural, or Specify: White 1 ☐ Yas 2 ☒ No Specify: P 3 Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Maintenance Foreman Manufacturing 9 years Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be next of Health and Mental Ruth M. Bruce Lowell E. Thompson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) important: If Item 27 is any Injury or other trau 7312 Geise Ave. Baltimore, Maryland 21219 Donna Thompson (Wife) 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Crametion 3 Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 2/28/2000 Bel Air, Md. 21. Signature of Funaral Service Licensee 22. Name end Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Dundalk, Maryland 21222

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast.

Approximately 1. Ap Approximate Intarval Between Onset and Deeth **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Myocardia Examiner ORONARY eR V the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury thet initiated evants rasulting in death) Last and CARdIOVASCULAR DISEASE · ARIERIOSCIEROTIC Completed by Physician/Medical for use signed by the a Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CANCER Records, 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: Be 25. Was casa ratarred to medical axaminar? 26. Place of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? Mannar of Death 28d. Describe how injury occurred 28b. Tima of After 5 Panding invastigation Naturel 24 hours after death.

Funeral Director: Al 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, ferm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital Certifying Physictan: To the bast of my knowledge, death occurred at tha tima, date and place, and due to the causa(s) and mannar as stated.

[2 Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Cartifian completely (Check only one) within 2 4 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

**DHMH 16 Ray 6/95** 

State

Registrar

9000 FRANKIN SQUARE DR. BAIT, MORE MARY LAND Registrar's Signature & Sporks

ware, IV

mpleted cause ot death (Item 23a) (Type, Print)

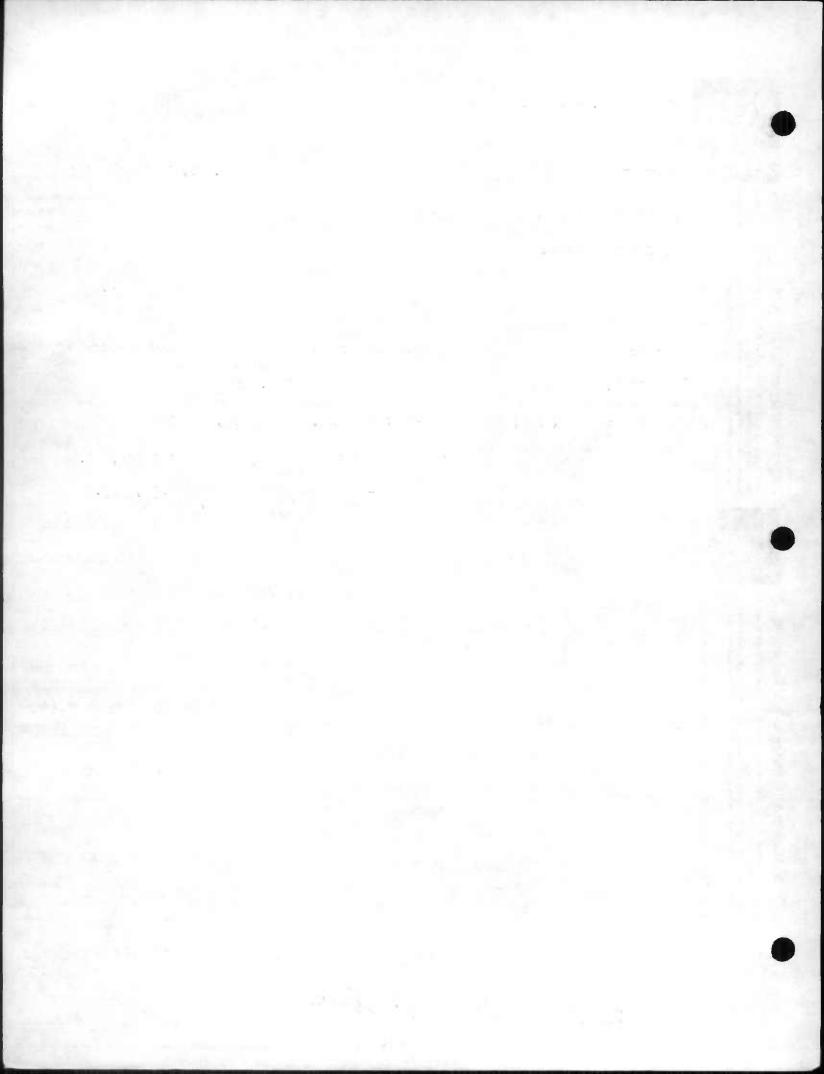
32. Registrar's Signature

30. Nama and addrass of person who

31. Dete tiled (Month, Day, Year)

DR. MARCO ZAMORA

FEB28



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

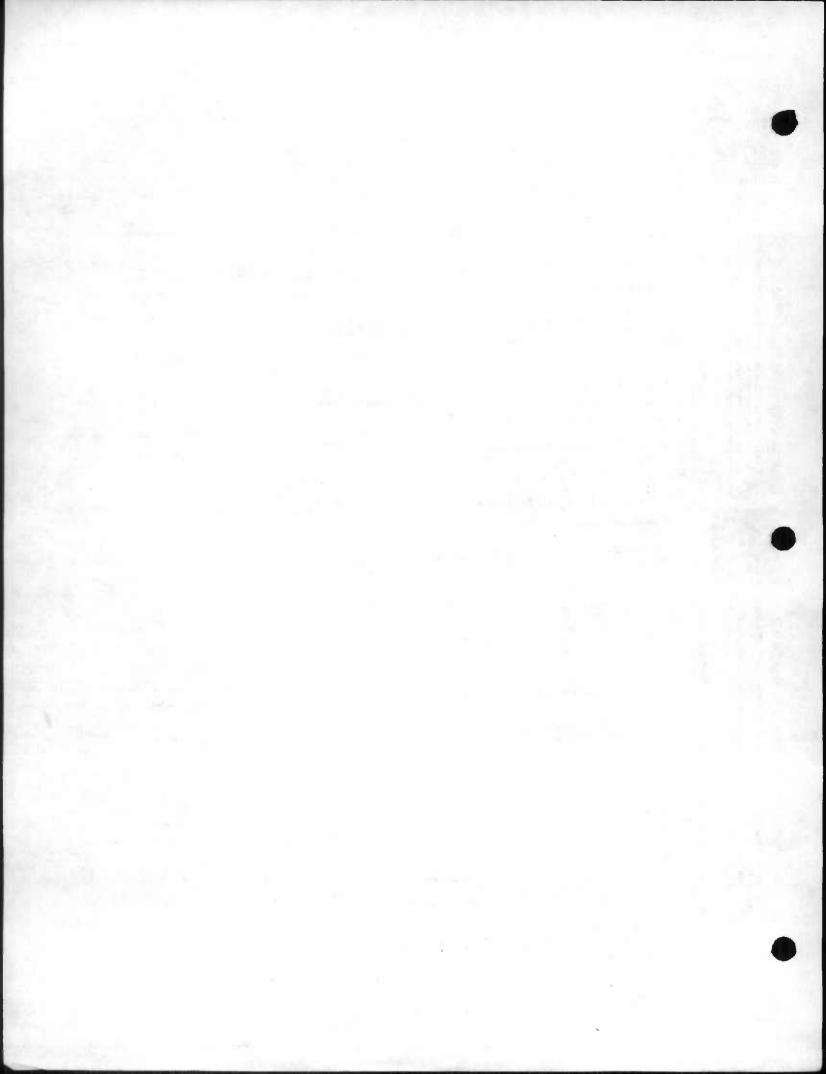
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						Cer	tificate of	f Death	R	leg. No.		0901.	
		Decedent's Nama (First, Middla, Last)							2. Data of Dea Month	th Day	Yaar	3. Tima of Death	
	Physician /Medical	Interpret Marten Infilitivetto								February 20,2000		4:15 P.M.	
Examiner		4a Facility Nama (If not institution, give street and number) 4b. City, Town,								or Location of Death 4c. County of Death			
	Johns Ho			edical 7. Age (In yrs.		If Under 1 Yea	Baltim or   Munder 24 Hrs			/A			
	Funeral Director	5. Social Security No. 212 15 68	(Month, Day	8. Date of Birth (Month, Day, Year)  Aug. 14, 1975  8. Birthplace (Stata or For Country)  Maryland									
2	Usual Rasidence of Dacedant  10e. Stata 10b. County 10c. City, Town or Location									1	Od. Inside City Limits		
	raho adal											1 ☐ Yas 2 ☑ No	
	or 28ed a be notified Director	10e. Street and Num				ntry?							
	The state	8424 Coco					101. Zip Code	237			JSA		
5-0020 72 Yours after death with the Marylar naturel, or heres 23e or 28e-f show sides Examiner must be notified at stead by Eumanal Director	11. Marifal Status			is 2 No Specify:				Specify Yas or No-	14. Rac	e - Amaric	can Indian,		
	or ster or the Examiner	1 ⊠ Nevar Marria	Armed For 1 Yas If Yas, Give Yaar or Da					erto Rican, atc.)  Black, White, atc.  Specify: White					
20	ted fred		15. Decedent's Education				ent's Usual Occ	upation	adria a	16b. Kind of B	usiness/In	dustry	
21	Med and	(Specify only highast grada complate Elemantary/Secondary (0-12) College			-4or 5+)	lifa. D	O NOT use reti	e during most of wo red)	irking				
2	ed within 72 to ygiene. ner than "natur it, the Medical. Completed	12				Car	penter			Const		ion	
Maryland 21215-0020	Mental H wantal H wheel oth site even	17. Fathar's Nama (I Michael J							ma (First, Middle, I con Chane	ie, Maiden Sumama) ney			
	and 2 she salth and n 27 is ma ser traum	19a. Informant's Na Michael J				8424	Coco F	et and Number or R Rd. Baltin	more, Md.	21237			
-	Pages 1 ment of H annt: If the lary or off		osition ] Cremation 3 [ 5 □ Othar <i>(Speci</i>		State	cematary, crem	e of Disposition (Name of atary, crematory or other place)  rkwood Cemetery 2/25/2000 Baltimore, Md.						
Ball	Departms Departms Importan any Injur STICS	21. Signature of fjunaral Sarvice Licensee  22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221											
7	Physician /Medical Examiner	Immediata Cause (F disaasa or condition rasulting in daath)			HANG	or as a consequ	uence of):					Interval Batween Onset and Death	
68760,	ntificate be executed ing physician and a set the burial-transit Medical Examiner	Sequantially list con if any, laading to lmi ceuse. Entar Under Ceuse (Disease or it that initiated events rasulting in death) L	njury	Dua to (c									
Box 68		rasuling in death) L		d						- 10	-	1	
	death ce attend ed for us siciar/	Part II. Other signific	cant conditions	contributing to de	ath but not res	sulting in the un	derlying ceusa	given in Part I.	23b. Did to	obacco use co	ntribute t	o the cause of death?	
<b>a</b>	es that the death ce igned by the attend be detached for us.  by Physician/					k c	T. St	W.	1 Yes 2 No 3 Probably 4 1			bebly 4 Unknow	
Records,	aw requir ss been s 2 should pleted								24a. Was a perfor	n autopsy med?	av	ere autopsy findings vallable prior to empletion of cause death?	
	Page Corr								1 1 1 Y	as 2 No	11	as 20 No	
ā	certificate rector, pa	25. Was case rafarre axaminer?	ed to medical					26. Place of De	ath (Check only or	10)			
2	hysic his ce al dire	1% Yas 2□ N	10	Hospital:	npatient 2	ER/Outpatient	3 DOA	Other: 4 Nursing	Homa 5 ☐ Resid	ence 6 □Oth	er (Speci	ý)	
5	fler th mena	27. Mannar of Death 1 ☐ Natural	5 Pending	28a. Data o (Mont/	of Injury h, Day Year)	28b. Time of tnjury	28c. In	jury at lork?	28d. Describe h				
Sio	Attending Physician: or death. sector: After this certific by the funeral director, iffication: To Be (	2 ☐ Accident	Invastigation	0	900	6110A	M 1	Yas 2 No	Yes 2000 SWOJER HOMED				
Ö	व व व व	4 Homicida	determined	286. Place	of Injury - At hing, etc. (Special	(y) _	et, factory, offic	0	City or Tow	reet and Number, State)		BANNONS	
	To the Hospital within 24 hours To the Funeral completely filled Medical C				sis of axamina			time, date and place opinion, death occ			anner as s	stated.	
	withir To the comp	29b. Signatura and t	itla of certifiar	Λ	n.	,	29c. Lice	nse number	2	9d. Data signe	d (Month,	Day, Year)	
		Hou	Inte	Mel	houl	n 23a) (Type F		O.C.M.E.		Februar	cy 2.2	, 2000	

Registrar

State

111 Penn Street, Baltimore, Maryland 21201



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06452 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Jacqueline Turpin 21, FEB. 12:30 PM 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hanover 1311 Hill Born Rd. Anne Arundel If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 F Months 585-24-6709 53 14, 1946 Wyoming Usual Residence of Deceden 10b County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Hanover 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1311 Hill Born Rd. 21076 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Sullivan

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Raymond Becker 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Hill Born Road, Hanover, Thomas Turpin - husband Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/25/00 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lig Gary L. Kaufman Funeral Home@ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.

Physician /Medical Examiner

ettending physician and for use as the buriel-transit

the signed by t

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page 2 s

director. Be

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After

To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun

or Attending

that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vitai

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Martiel Hygians. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show with Injury or other traumstic event, the Medical Examples must be notified an

Baitimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

8

Examiner

Physician/Medical

by

Completed

10

Certification:

edical

MD

**Funeral** 

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

deno archama mounter Due to (or es a consequence of) Due to (or es e consequence of):

Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

21076

21075

Approximate Intervel Between Onset end Deeth

no

24a. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death? 1 Yes 2Q No 1 ☐ Yas 2 ☐ No

21/2000

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home A Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work?

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1/2 Natural 1 Yes 2 No 2 ☐ Accident

6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and fille of certifie 29d. Date signed (Month, Day, Year)

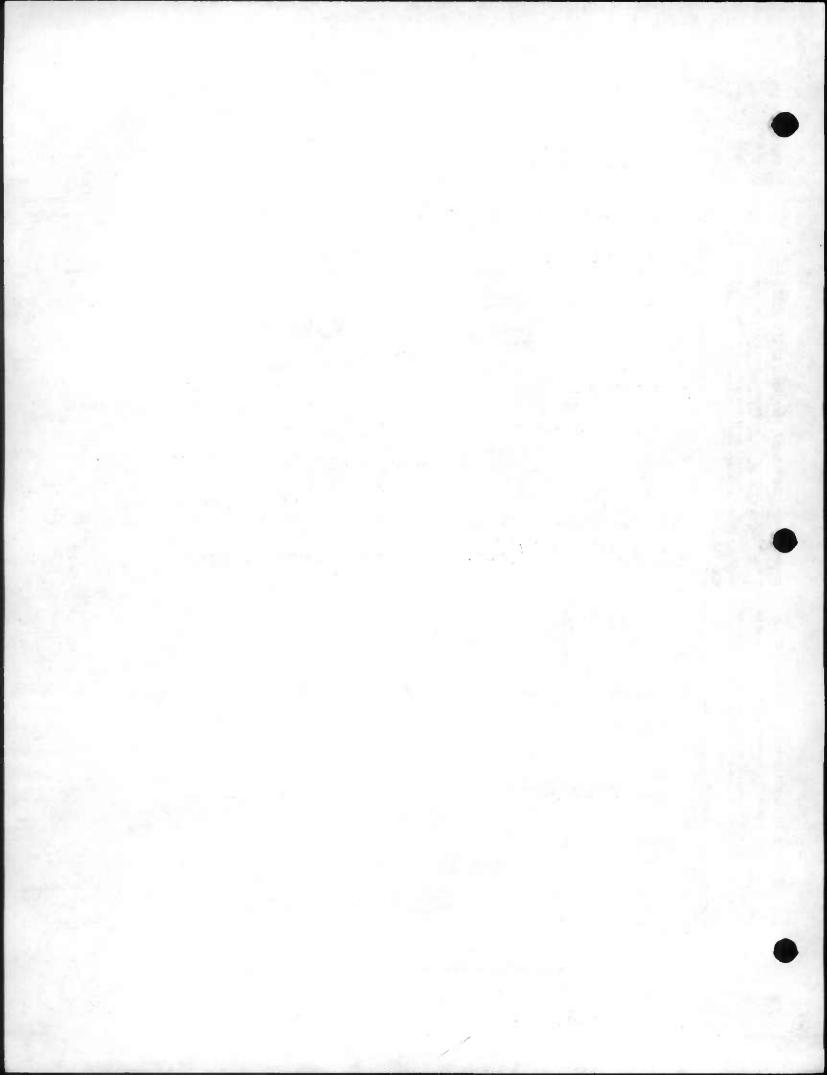
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd, Annapolis MD INS Hanlo 31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

FEB 2 8 2000

32. Registrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Physician Month Shelton 4b. City, Town, or Location of Death 4c. County of Deeth Whitworth 1905 /Medical 4a Facility Name (If not institution, give street and number) Examiner Baltimore Hopkins HOSPITAL John If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 10M 20F 44 Yrs. 214-64-4359 MARYLand Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Medical Examinar must be roothed at 1DYas 2 No Baltimoree Director MARyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 4803 CROWSON STREET USA "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLack altimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Hill + Hill company Labor 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be William Curtis Barbra Whitworth 19a. Informant's Name/Relationship (Type, Print) (MoTheir) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Barber Whit worth ShAdwell Court Balto. Co. MD, 21244 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 D Burial 2 Compation 3 Removal from State Balto. Co., Mi) 123/00 ring Mumorial PK Jeff Millen Funeral Howl 22. Nama and Address of Facility N. BRoadway 1639 Balto. M.D 21213 23a, Part. Enterthis disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical Acquired Immonod diciency Synd nome Due to (or as a consequence of): UNKNOWN Examiner Circ hosis UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Stage Records, P.O. Box 68760, Renal disease (MKnow N Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 □ Ves 2 □ No Division of Vital Be 25. Was casa refarred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 결 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred Attac Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death after death Director: 6 ☐ Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours at 26 the Funeral DI completely lifed it 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signatura and titla of certifier 29d. Date signed (Month, Day, Year) Enic Yang , MiD ans Nes.000 frh1001-70 4,000

State Registrar Eprc Yang

31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

ORIGINAL

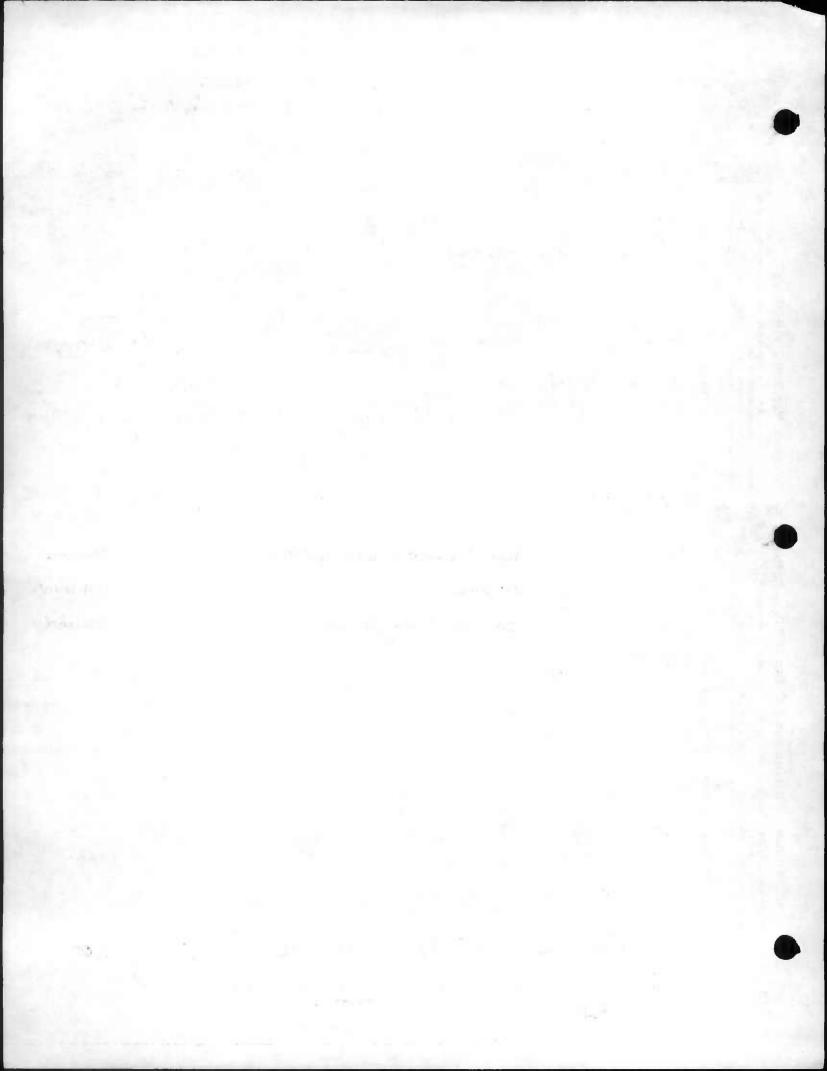
Baltimor MD 21287

ss of person who completed ceuse of death (Item 23a) (Type, Print)

32. Regist

FEB 2 8 2000 >

600 N. Wolfe Street



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** WILLIAMS FRANK FEBRUARY 23 2000 /Medical 4a. Fecility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PANDAUSTOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 1€M 2□F 215-12-5025 81 Director Dec. 17, 1918 NC Usual Rasidence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours effer death with the Manylan Department of Health and Mentel Hygiene. Important: if item 27 ie marked other than "natural", or items 23e or 28a-4 show any injury or other traumetic event, the Modical Examinal fixed to Amiliad at Md. n/a Baltimore Director 1 Syes 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5 S. Abington Avenue 21229 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Nevar Marriad 2 Married 1 □ Yas 2 □ No If Yes, Giva Year or Datas: Maryland 21215-0020 1 Tes 2 No Specify: þ Specify: Black 3√Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Crane Operator Bethlehem Steel 7th Grade 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Edward Williams Jane Douglas 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Rhoda L. Jones Daughter 4100 Paran Road Randallstown, Md. 21133 Baltimore, 20b. Pleca of Disposition (Name of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 □ Cramation 3 □ Removal from Stata 4 □ Donation 5 □ Othar (Specify) Meadowridge Mem. Park March 1 Elkridge, Md. 21. Signature of Funarai Sarvice Licensee 22. Nama and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Herber 23e. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** YMPHOMA /Medical Immadiate Ceusa (Final diseasa or condition resulting in death) Examiner Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Entar Undarfying Causa (Disease or injury that initiated evants resulting in death) Lasf Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or es e consequance of): Part if. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 23b. Did tobacco use contribute to the cause of death? isigned by t 1 Yes 2 No 3 Probably A Unknown Records, þ 24b. Ware autopsy findings sveilable prior to complation of cause of death? Completed 24a. Was an autopsy performed? 2 000 1 Yas 2 No 1 ☐ Yas certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral Director: After this certification in the funeral director; p. 25. Wes case referred to medical Be 28. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas > No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 QNetural 5 Panding 2 Accident invastigation 1 Yes 2 No 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and menner as stated.

Implicate Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29a. Certifier 29b. Signatura and title of certifier 29c. License numbar 29d. Data signed (Month, Day, Year) 37333 REBRUARY 23, 2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

State Registrar

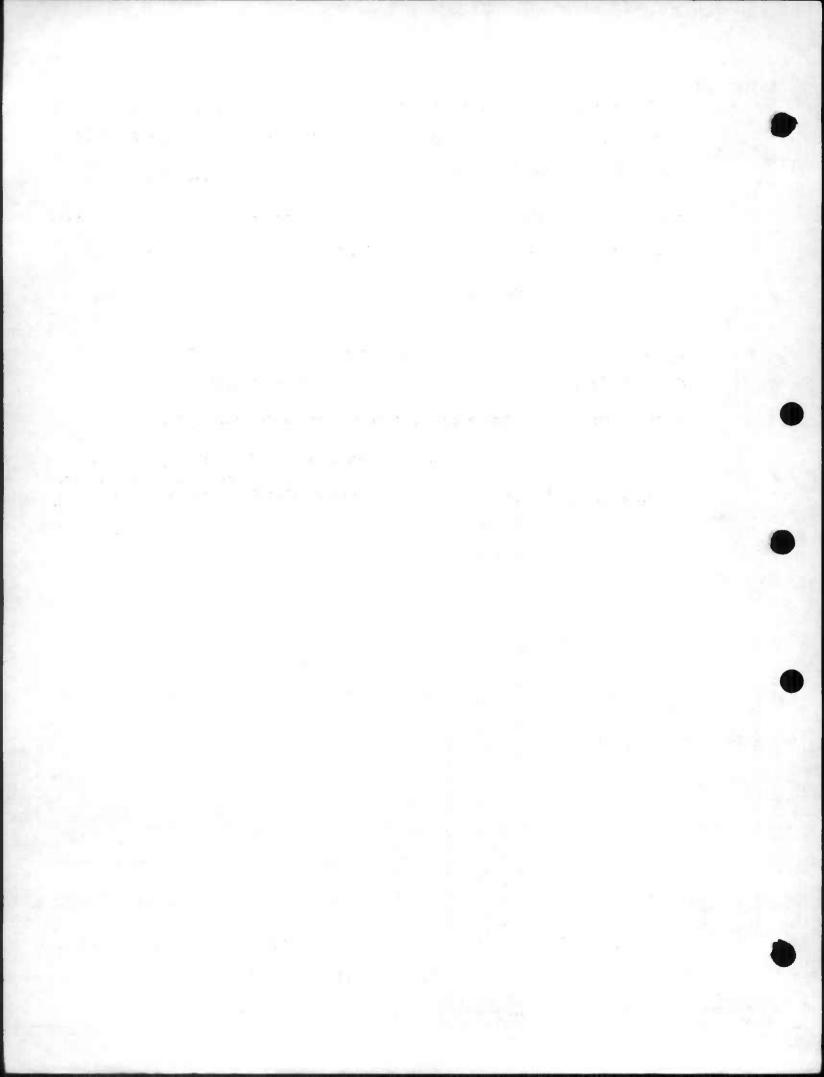
31. Data filed (Month, Day, Year)

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32. Registrer's Signatura

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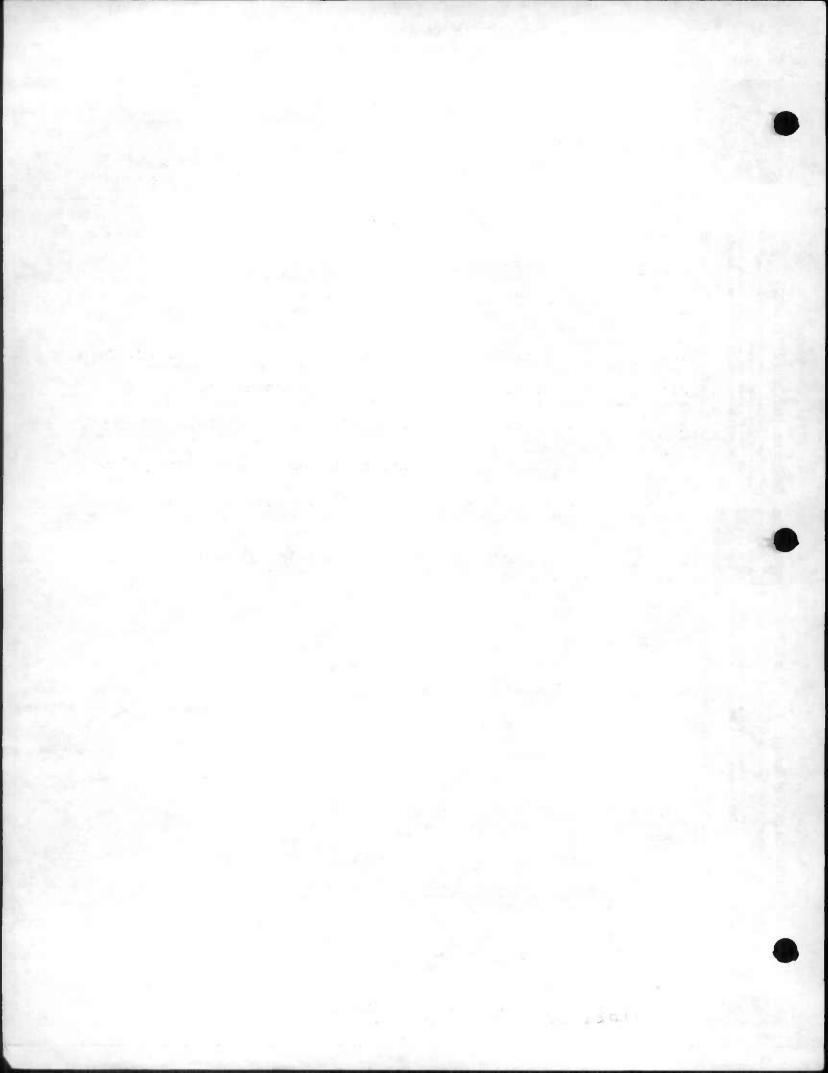
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-1015-510 State of Maryland / Department of Health and Mental Hygiene 06455 JOHNNY WASHINGTON Certificate of Death JVW 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Washington Sr. Johnny FEBRUARY 20,2000 08:42 A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 24 Hrs. | p MARYLAND GENERAL HOSPITAL 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Yaar Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 17 M 2□ F Director 213-64-5407 11 55 05 08 M.D. Usual Residence of Dece 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits show XXYas 2 No Director 288-1 Baltimore MD NA 8 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? b 1206 Druid Hill Ave 21217 U.S.A. flerns 23s Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after 1 Yes 2 No XNever Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: 3 3 ☐ Widowed 4 ☐ Divorced Black Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) S.E.C. Company 12th grade Laborer Pages 1 and 2 should be filed nent of Health and Mental Hygis net; if them 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Elizabeth Bradley Jerome A. Washington 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Item 27 is any injury or other trau anos. 5114 Laurel Ave, Baltimore Md 21215 Bea Cawthorne-Sister 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2-26-00 Randallstown, Md m of Funaral Service Licenses 22. Nama and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part Lines the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Batween Onset and Death **Physician** Cardingocular Processe /Medical Immediata Cause (Final Atheroseleertx disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burief-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): for use as 136 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 signed by t 3 Probably 4 Unknown 1 Yes 2 No 2 should I 24a. Was an autopsy performed? 24b. Wara autopsy tindings svailable prior to Completed completion of cause of death? paga 2 s 16 Yes 2□ No Yas 2 No certificate Division of Vital Attending Physician: director, Be 25. Was case ratarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) toxYas 2 No Certification: To 1 ☐ Inpatient 2 ☐ AP/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation After Natural
2 Accident death. 1 ☐ Yas 2 ☐ No Director: / 6 ☐ Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 Homicide ð vithin 24 hour within 24 hours aft To the Funeral Dis completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Certifier edical (Check only one) 29b. Signature and title,of certifier 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. huten Deure February 21, 2000 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Dennis J. hute, mp 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB28

**DHMH 16 Rev 6/95** 

Registrar

2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#25,27,28a-f perPhyG780 2/28/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yee Teresa Ann Windfelder 13 FEBRUARY OF 2000 /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE

H Under 1 Year | If Under 24 Hrs. | 8. Date

Months Days | Hours | Min. | (Mor HEALTH CARE AGNES 8. Date of Birth (Month, Dey, Year) 07 17 1908 Birthpiace (State or Foreign Country)
 M d 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F 216-09-7569 91 Yrs. Director Usuel Residence of Decedent tind within 72 hours after death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. Miner than 'naturel', or liems 23e or 28e-f show ent, the Medical Examiner must be nolling at 1 Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 21 Poplar Avenue USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic OrlgIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Switchboard Operator Montgomery Wards 8 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Pages 1 and 2 should be nent of Health and Mental George Yaeger Elizabeth Schwartzkopf The and Ment 7 is marked fraumatic 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) out of Health a vet; if them 27 is ver off 4309 Wendover Rd. Baltimore, Md 21218 Edward Windfelder, Jr/son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Buriai 2 □ Cremetion 3 □ Removal from State Department of important if any injury or New Cathedral Cemetery0208 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility
Sterling-Ashton-Schwab Funeral Home, 736 Edmondson Avenue, Balto, Md. 1 21228 23a. Pert1. Enter the disease, or controllections that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) SUDDEN CARDIAC ARREST DAY Examiner Due to (or as e consequence of): MALFUNCTION
equence of: Examiner PACEMAKER Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Physician/Medical Due to (or es a consequence of) 980 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings availeble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 1 ☐ Yes 2 No 1 Yes 2 No sion of Vital ND FELDER or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Certification: To 27. Menner of Deet 28b. Time of injury 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 2 Accident 5 Pending investigation after death. Director: Af 1 Yes 2 No Pacemaker Malfunction 2/05/2000 12:00 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 21 poplar ave Catonsville, Md Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medicat Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) RESIDENT FEBRUARY 09, 2000 MEDICAL 30. Name and indress of petion who completed ceuse of deeth (Item 23a) (Type, Print) CATON AVENUE BALTIMOIZE MD 2/229 900 KICHARD ADD O OFFEI

32. Registrer's Signeture

Registrar

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31. Dete filed (Month, Dey, Year)

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Records, P.O. Box 68760

Division of Vital

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Physician:

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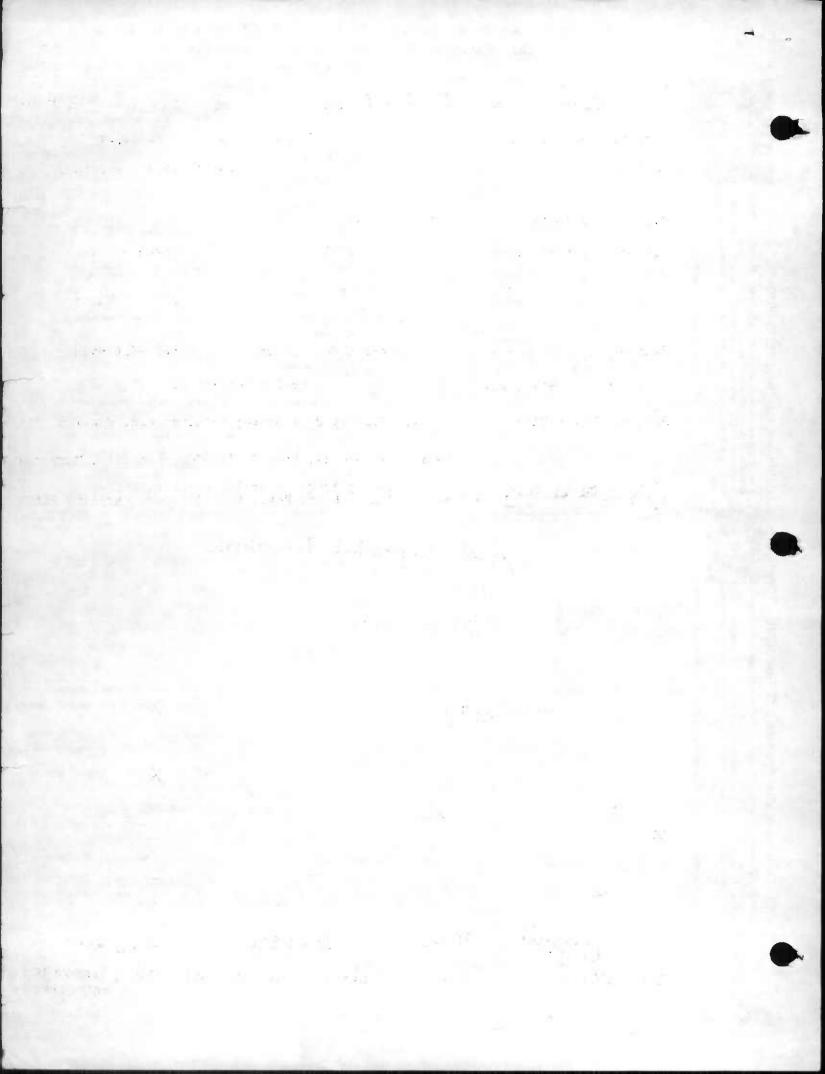
death

Registrar

31. Data filad (Month, Day, Year) FEB28

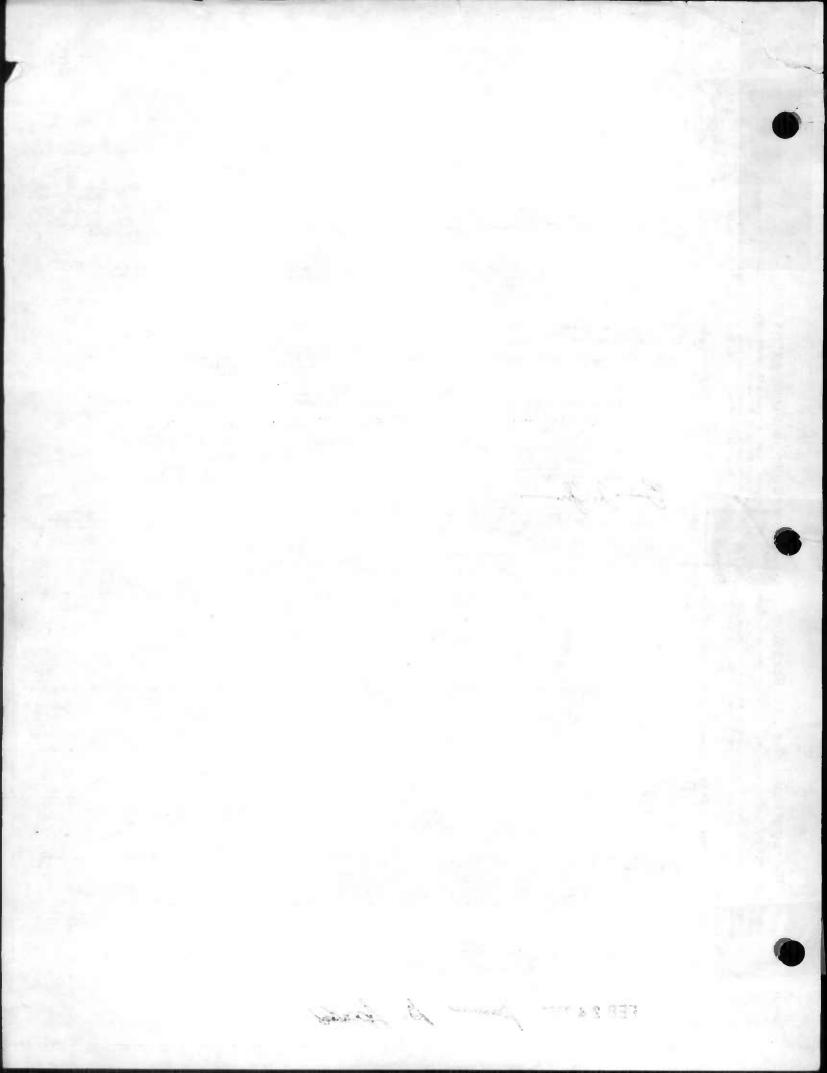
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32. Bagistrar's Signatura



00-1027-003 Amended Itrem#16b perFHG781 3/13/2000 EW
MICHAEL JOSEPH ALLEN Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ASP 23a,b,27 per me G781 3/8/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Michael FEBRUARY 20 2000 Joseph Allen. 2045 /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2016 OUAY VILLAGE ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington D.C. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1947 **Funeral** Months Days Hours 10 M 20 F 215-46-3996 Dec. Director Usual Residence of Decedent the Maryland 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural; or itema 23a or 23a-f show any Injury or other traumatic event, for the death of the Injury or other traumatic event, for the death of the Injury or other traumatic event, for the contribution of the Injury or other traumatic event, for the contribution of the Injury or other traumatic event, for the contribution of the Injury or other traumatic event, for the Injury or other traumatic event, for the Injury or other traumatic event, for the Injury or other traumatics are injury or other traumatics. 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2016 Quay Village 21403 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Bleck, White, etc. TYPES 2 No 1965— If Yes, Give Yeer or Detes: 1968 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify by 3 ☐ Widowed 4 🖾 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Theater 4 Sound Engineer Engineering 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Harry Allen Louise Joseph 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Page Winter Allen/ Ex-wife 3405 Newport Avenue Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 02-24-00 Brentwood, Maryland Ft. Lincoln Crematory 21. Signeture of Funeral Service Licensee John M. Taylor Funeral Home, Inc. 22. Name end Address of Fecility 147 Duke of Gloucester Street Annapolis, Md. 21401 23a, Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervet Between Onset end Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical FATTY LIVER PATTY LIVER Examiner Due to (or es a consequence of) Examiner CHRONIC ALCOHOLISM attending physicien end for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or es e consequence ol): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. Division of Vital Records, P.O. 3 Probably 12 Inknown 1 Yes 2 No ò 24b. Were autopsy lindings aveilable prior to 24a. Wes en autopsy parformed? Completed completion of cause of death? Wes Yes 1 Yes 2 No 2 No 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Aftert Certification: 5 Pending investigation 1 XNeturel death. 1 Yes 2 No s after death i Director: // d in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, lectory, office building, etc. (Specify) illed in by 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E FEBRUARY 21,2000 husen 30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Dennie U e ms 31. Dete liled (Month, Dey, Year) 32 Registrer's Signeture State FEB 2 4 2000 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month BAUGHER KATHRYN C. 29 0452 Jan 2000 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Il Under 24 Hrs. Howard If Under 1 Year 8. Dete of Birth July 7, 1920 Birthplace (State or Foreign Country) WISCONSIN 7. Age (In yrs. last birthday) 10 M 20XF Days Hours 79 Yrs. 390-12-8260 Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Woodstock 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4 Offutt 21163 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Bleck, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: white TTWW 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Clark Mayme Nee 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Leigh Hunt / daughter Offutt Ct. Woodstock, Maryland 21163 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Jan. 29 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 Donation 5 Other (Specify) Metro Crematory Catonsville, Maryland 2000 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licenses him JP010M 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart leiture. List only one cause on each line. Approximete Intervel Between Onset end Death tmmediate Cause (Final disease or condition resulting in death) 40 hours pneumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown synurome SINUS 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

10a State

Directo

Funeral

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Completed

Examiner

**Funeral** 

Director

parmit. Pages 1 and 2 should be filled within 72 hours efter death with the Merylan Department of Heelih and Mantei Hyglans. Important: If item 27 is marked other than "natural", or hams 23a or 28s-f show with injury or other treumatic event, the Medical Exemination noutled at page.

Baitimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vitai Records.

Examiner Physician/Medical þ Completed Be 10 Certification:

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physician and the burier-transit certificate be executed 080 eigned by 108 his After t or Attending To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

1 Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 3 No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation 6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2□ER/Outpatient 3□ DOA

28c. tnjury at Work? 1 Yes 2 No

28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year) Jan 29, 2000

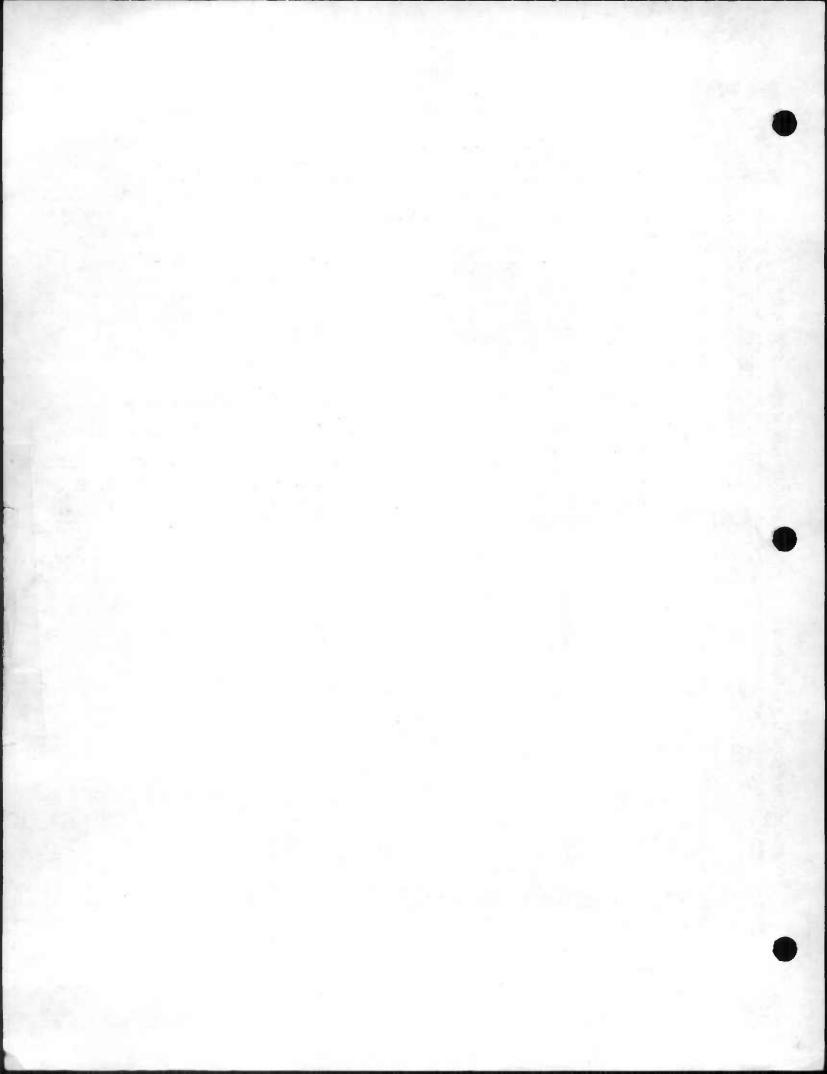
State Registrar

broma 31. Date filed (Month, Day, Year) 2000

MD, 11085 Cittle 32. Registra/s Signature Geneva

ss of person who completed cause of death (Item 23a) (Type, Print)

Patux. Akwy, Columbia, MD 2/044

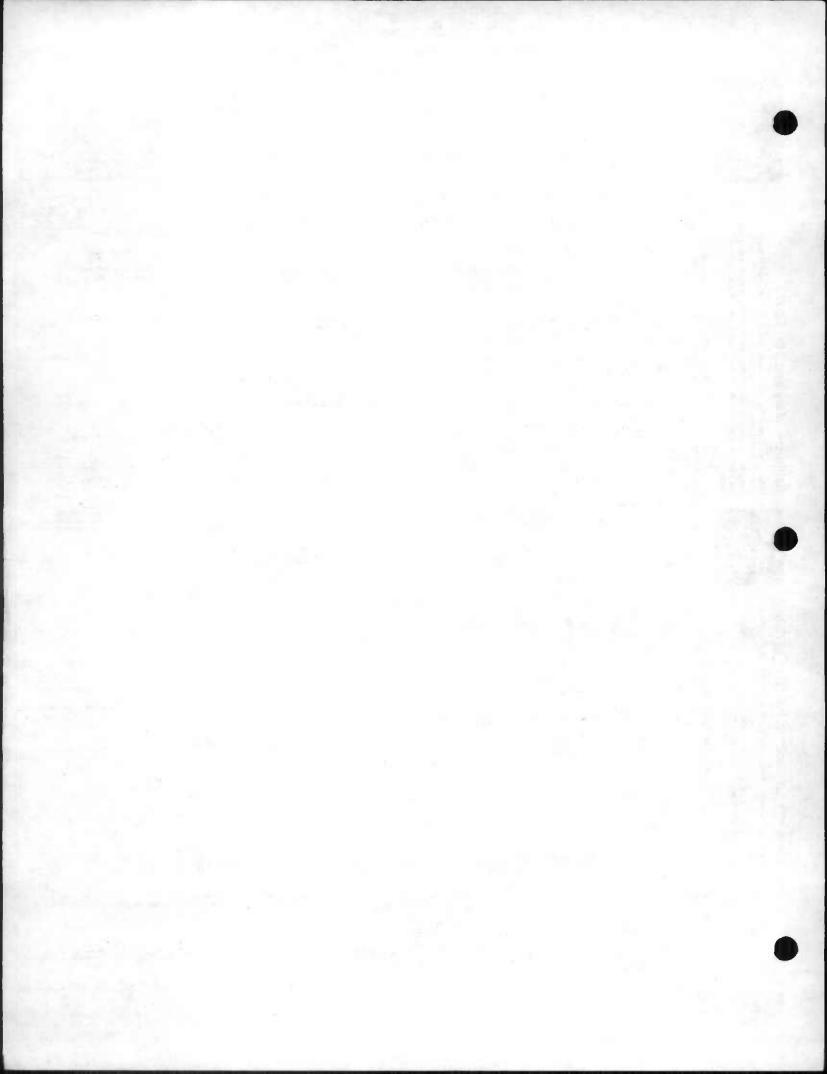


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06460. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Dete of Death Dey Year Month **Physician** BLESSING DOROTHY ~ SAM 30 12000 JAN /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10369 A Twin Rivers Rd. Columbia Howard If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20F Yrs. 218-74-5665 70 Director 20, 1929 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland notifie Howard Columbia 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? must be r 10369 Twin Rivers Rd. 21044 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status hours after 1 Yes 2/20No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Hygiene. other than "natural", o ent, the Medical Exan Specify 300Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Medical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If them 27 is marked off jury or other traumatic even jury even jur 8 Ernest Wallace Bird Ellen Pike 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Blessing / son Columbia, MD. 21045

Dete 1 20c. Location - City or Town, State 8610 Cobblefield Dr. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Feb. 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Department of Important: If any Injury or Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2000 Catonsville, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility, Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 MOIOGL 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Atherosclerotic Cardiovascular disease /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Insulin Dependent Diabetes mellitus Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last pue Due to (or as e consequence of): physician s the buriel P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown ata has been signed by page 2 should be detac 1 ☐ Yaa 2 ☐ No la proscopic choleaystectory Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was an autopsy 1 Yes 2 No 1 Yes 20 No Division of Vital Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Matural 5 Pending e Hospital or Attending 24 hours after death. e Funeral Director: Aft 1 Yes 2 No investigetion 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely 1 (Check only one) 29d. Date signed (Month, Day, Year) 295. Signature and title of certifier 29c. License number Deputy 314 30,2000 MN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Way Elicott City MID A-TOTE, MD PATRYCE 4565 Hemlock Cone 31. Date filed (Month, Day, Year) 32. Registgar's Signeture State FEB 0 1 2000 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06461 Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** BEAN 1:45 pm JUANITA FEB 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2\X Hours Months 74 Vrs. 218-24-0164 1925 Virginia Director May 26, Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 25a-f show YXYes 2□No Directo Fulton MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 238 20759 USA 8149 Stabean Drive Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armad Forces? 11. Maritel Stetus hours after 1 Yes 2XXNo
If Yes, Give
Yeer or Detas: 1 Nevar Married XX Married altimore, Maryland 21215-0020 ò 1 ☐ Yes 2 OXNo Specify: Specify.White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Key Punch Operator U. S. Government 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) Pages 1 and 2 should be fa ment of Health and Mental H ant: If Item 27 is marked off lury or other traumatic even Be Conard Reuben Horton Ella Mae Goad 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3251 Gamber Road, Finksburg, MD, 21048 Garnet Stanley Bean/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 2/7/2000 Catonsville, MD 4 □ Donetion 5 □ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, Maryland, 20707 aneco Approximata Intervel Between Onset and Death 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Finet disease or condition rasulting in daeth) /Medical 3 weeks SEPSIS Examiner Due to (or as a consequence of): Examiner 3 weeks PNEUMONIA The law requires that the death certificate be axecuted the burial-tran Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last Due to (or es e consequence of): pug Box 68760. KENAL FAILURE Physician/Medical Due to (or as e consequence of): signed by the atte P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed ANEMIA CEREBROVASCULAR DISEASE 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificata or Attanding Physician: funeral director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: | Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Deeth 28a. Date of tnjury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. tnjury et Work? Affer Naturat 2 ☐ Accident 5 Panding death. 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end mennar stated. 29e. Certifier Medical completely (Check only one) the th 29c. Licensa number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifial 2000 D50616 Tuesnat 30. Name and addrass of person who completed cause of daeth (Item 23a) (Type, Print) MARY PIEPEZAK MD FILE MAIDEN CHOICE LANC BALT, MD 21229

Registrar

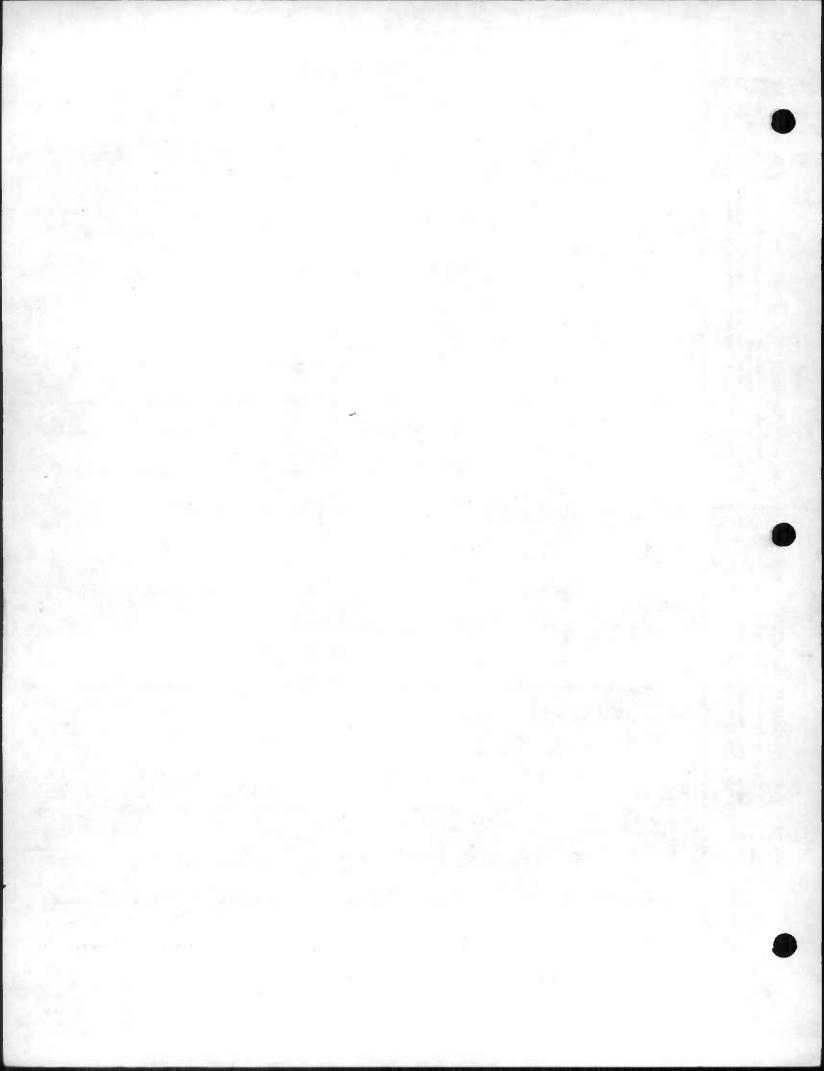
State

31. Date filed (Month, Day, Year)

07

DHMH 16 Rev 6/95

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06462 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Physician CATHERINE E. BLUCHER 10.25 PM 04 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSP. COLUMBIA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Oct 22, 1910 5. Social Security Number 6 Sex Birthplace (State or Foreign Country)
 Maryland **Funeral** Hours 1□M 2X F 214-34-8911 88 Director Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 No Yes 2 No 28a-f Directo Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be n 5285 Five Fingers Way 21045 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hy ant: If them 27 is marked oth lury or other traumatic event William H. Runkles Bessie Jane Becker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Blucher /daughterinlaw 15317 Bond Mill Road, Laurel, Maryland 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Department of Important: If sany injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 2/5/00 Metro Crematory, Inc. Catonsville, Maryland 21 Signature of Funadal Sandra Licenses 22. Name and Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) honrs Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner menn the buriei-trensit The law requires that the desth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as e consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 100 3 Probably 4 Unknown arellines, hypothe 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: | Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? After t 1 ☑ Natural 2 ☐ Accident Division 5 Pending investigation ie Hospital or Attending n 24 hours efter deeth. ne Funeral Director: Afti 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Redical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D36845

State Registrar 31. Date filed (Month, Day, Year) FEB 07 2000

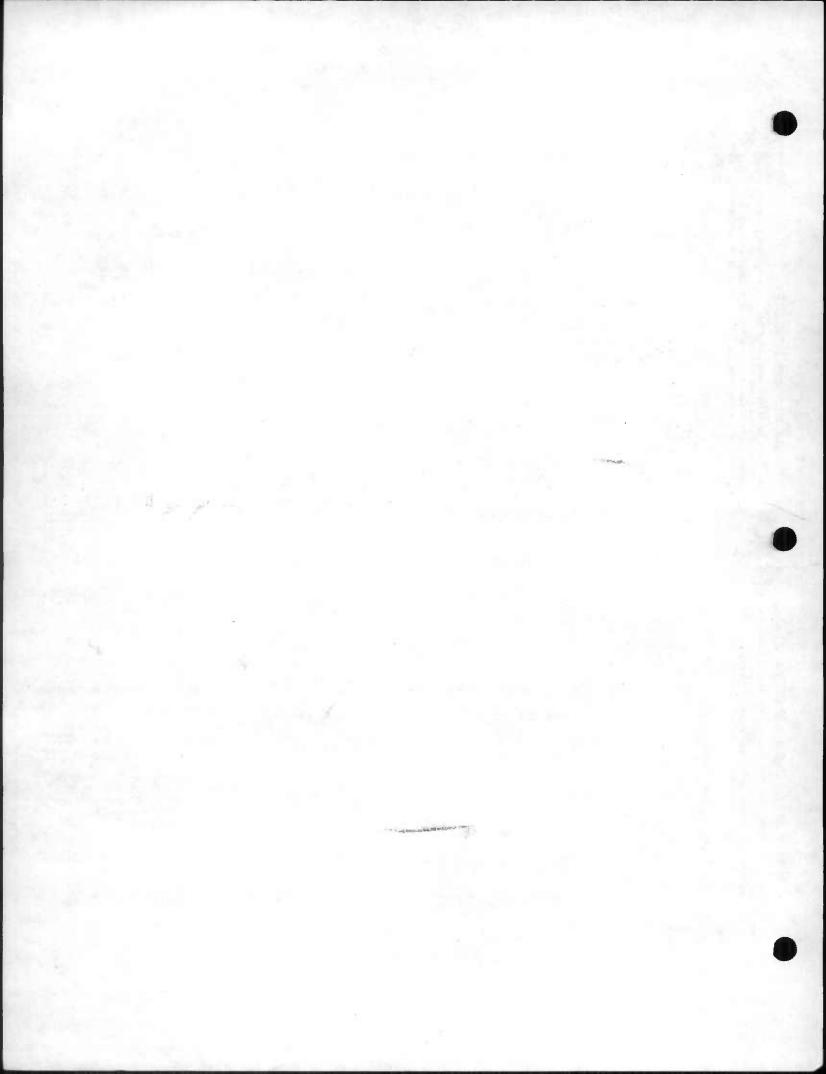
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Drive Columbia 32. Registrar's Signature Jeneva

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MAI-Ct+1

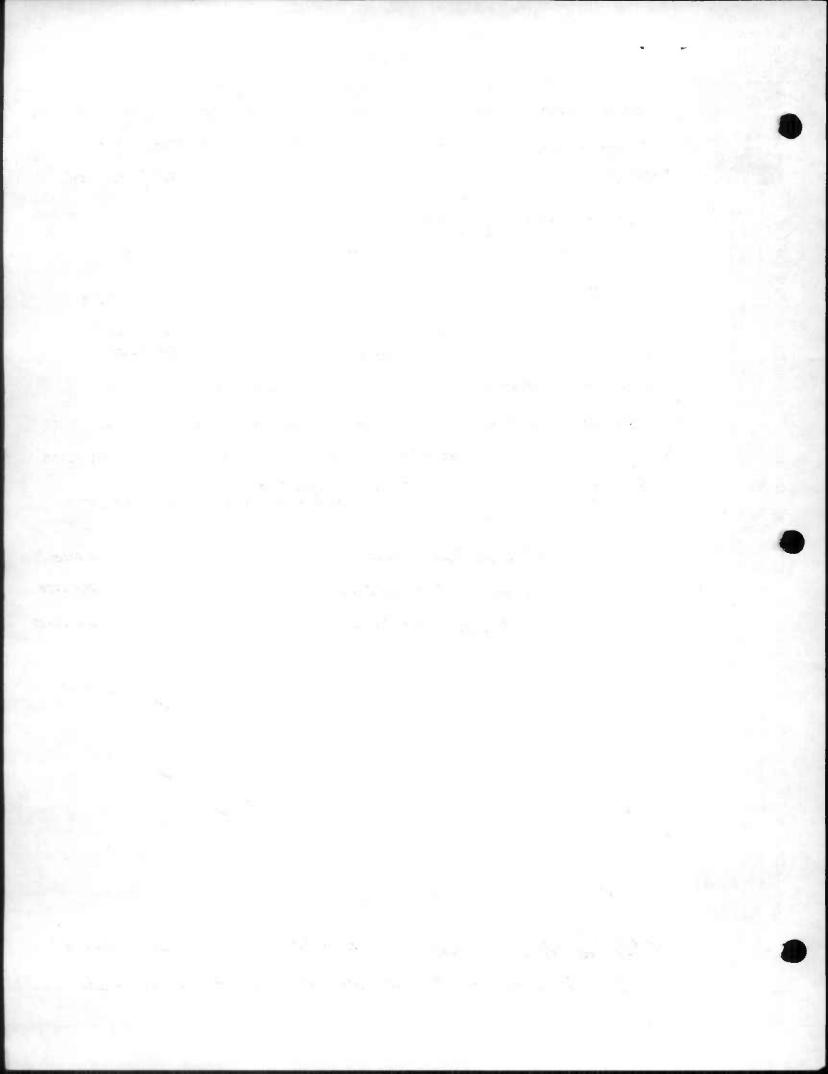
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06464 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Carlson Month Year **Physician** Theodore JANUARY 18:14 31 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOPKINS Hospital N/A If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ye N Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 MM 2□ F Yrs. Michigan 76 Director 344-14-0141 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐No Director Ellicott City Maryland Howard 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3004 North Ridge Road Apt 332 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1942-46 1 Never Married 2K Married 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mortal important: If Item 27 is marked or any Injury or other traumatic eventice. Charles A. Carlson Maggie I. Rasmussen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 3004 North Ridge Road Apt 332 Ellicott City, MD Elfriede Carlson/Wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2-1-2000 Catonsville, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. Sham a Collins - Wty 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Bronchiolitis Obliterans Organizing preumonitis month disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 1 No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 1 (19 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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After

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

altimore, Maryland 21215-0020

State

Registrar

Medical

29a. Certifier (Check only one)

29c. License number RES-000

29d. Date signed (Month, Day, Year) JANUARY 31, 2000

30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

1620 McElderry Street, Baltimore, MD 21205 Samuel Yang, M.D.

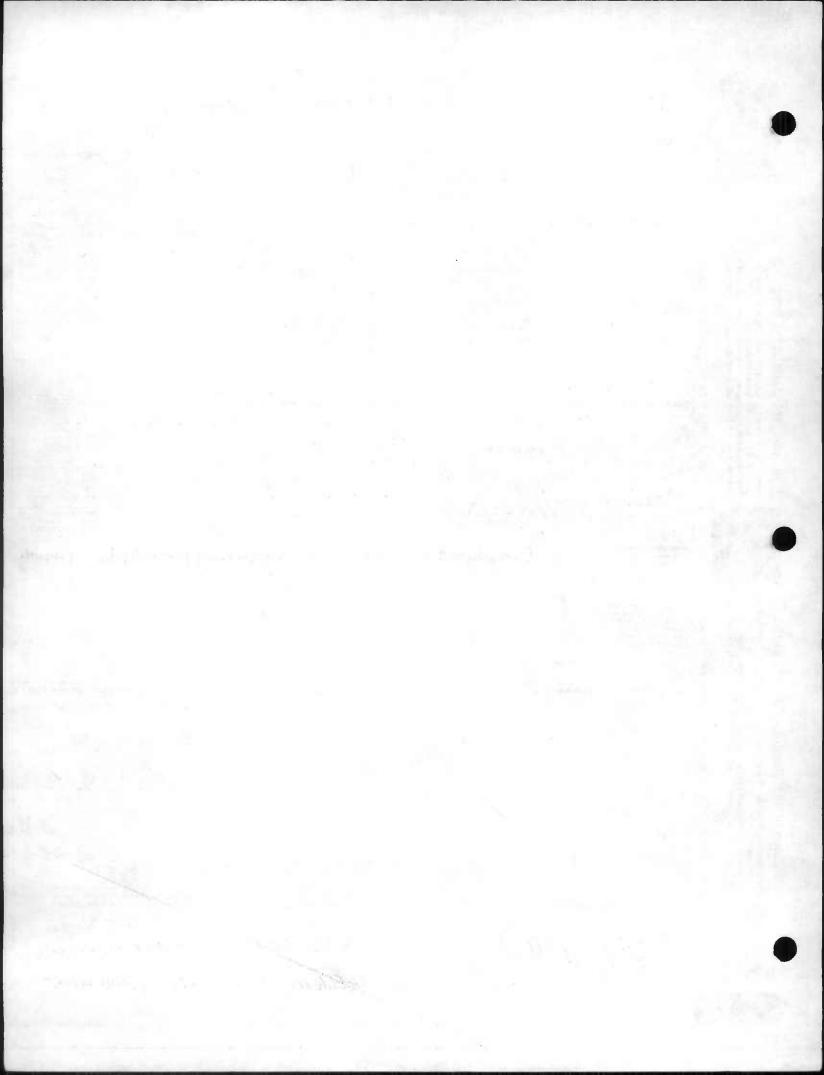
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) FEB 0 2 2000

29b. Signature and title of certifier

32. Registrar's Signature Geneva



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1 Decedant's Nama (First Middle Lest) 3. Tima of Death Day **Physician** Hazel Anne Coffman 6:00 pm January 31, 2000 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13597 Higland Road Clarksville If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Yaer) Birthplace (Steta or Foraign Country) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. Montana **Director** 60 May 29, 1939 Usual Residence of Decedant the Maryland 10c. City, Town or Location r 28a-f show 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Howard Clarksville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Madical Examiner grunt be r 13597 Highland Road 21029 U.S.A. Funeral death 12. Was Dacedant Evar in U,S. Armed Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14 Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or iter any injury or other fraumatic event, the Medical Examinations. 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Giva X Yaar or Detas: Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementary/Secondery (0-12) College (1-4or 5+) Music Writer 18 Mothar's Nama (First Middle Maiden Sumama) 17. Father's Nama (First, Middle, Last) Edward Nicholas Young Annie Elsie Spicer 19b. Mailing Addrass (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 13597 Highland Road, Clarksville, Maryland 21029 Donald D. Coffman /spouse 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1 ☐ Buriel 2 ☑ Crametion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 2/1/00 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Sarvice Ligg 22. Nama and Addrass of Facility Donaldson Funeral Home, P.A. 23a. Part 1. Entar the disaasa for complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximate Intervel Between Onset and Death **Physician** Immediete Ceuse (Finel disaase or condition rasulting in death) /Medical Overian (ancor Examiner Dua to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) use as t 23b. Did tobacco usa contributa to the cause of death? datached Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yas 2 No 3 Probably 4 Unknown signed b Division of Vital Records. þ 24b. Wara autopsy findings available prior to complation of cause of daath? Completed 24e. Was en autopsy performed? page 2 s certificate has The 1 Yes 2 No 1 □ Yas 2 □ No Hospital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 10 After this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 PNatural 5 Panding investigation s after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 2 4 Homicida 24 hours 29a. Certifian 1/2 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. edicai completaly 2 Madical Examiner: On the besis of examination and/or invastigation, in my opinion, daath occurred at the time, dete end piece, end due to the causa(s) and manner stated. (Check only one) To the P within 2 29b. Signature and tipe of pertilie 29d. Data signed (Month, Day, Year) 29c. Licensa number

State Registrar 5-G1

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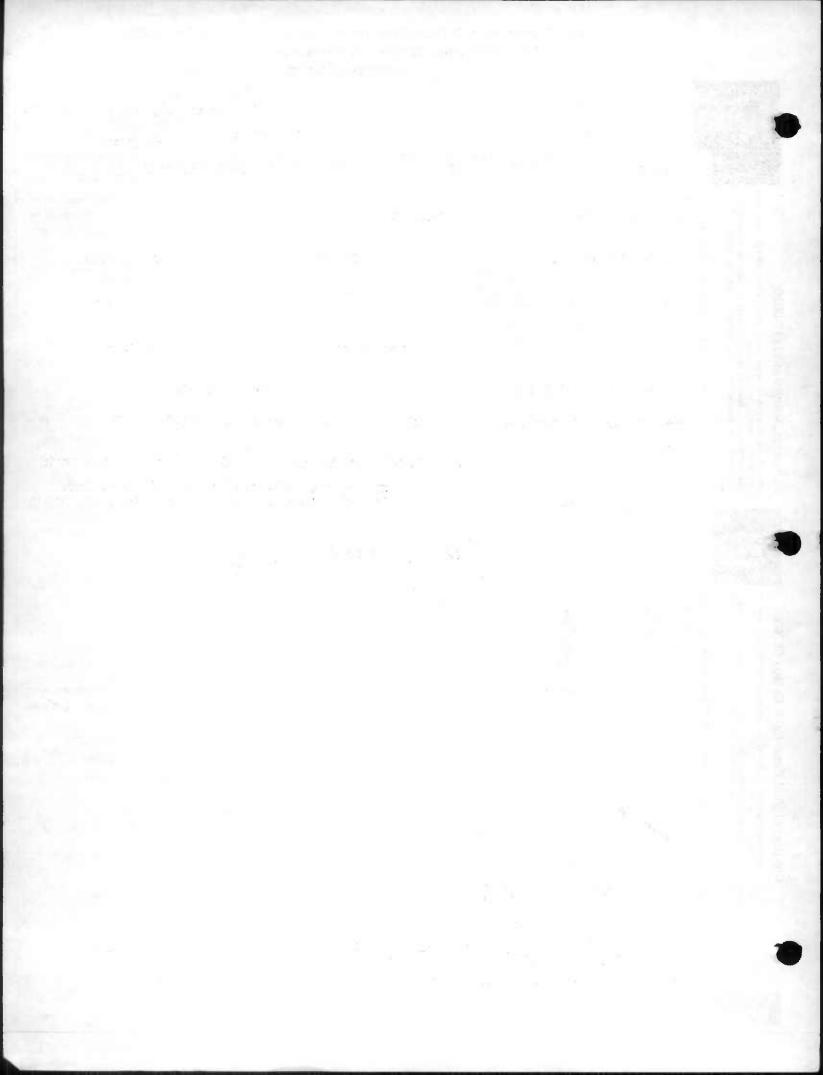
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State of Maryland / Department of Health and Mental Hygiene 00 06467

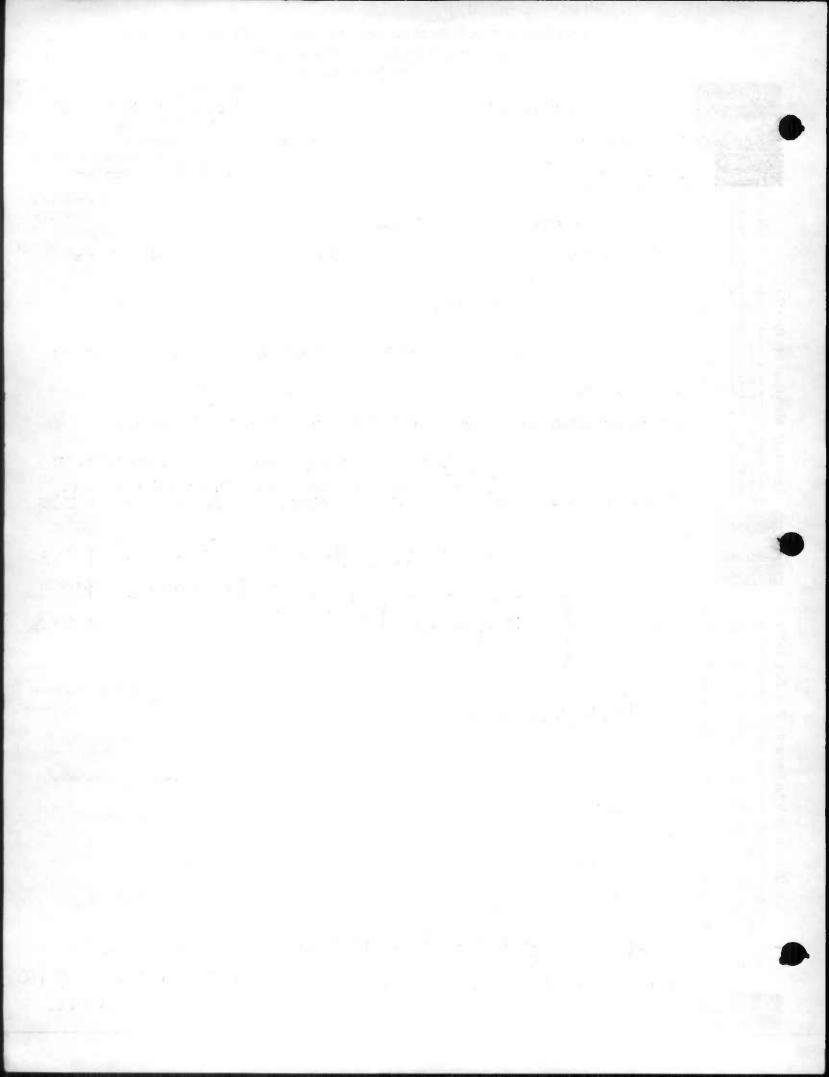
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State Registrar

Kathleen YORK-Smith 31. Data filad (Month, Day, Year)

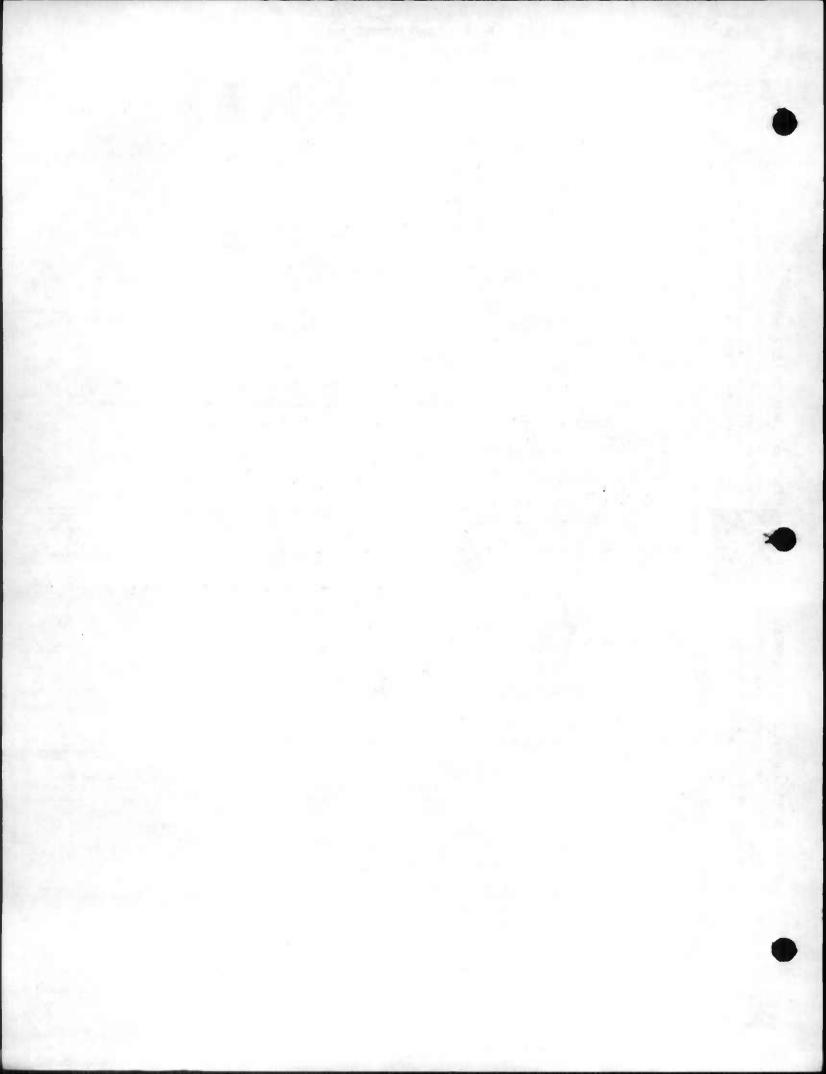
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

9501 Old Annapolis PD Ellicott Cof MD 21042



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #19a,2-17-00, SHS, Talbot Amended #26, (per MD), 02-03-00, SRR, Talbot Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 31 2000 2:10 A.M. Antione Courtney Jan /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel County Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10 M 20 F 212-92-9879 Director Mar. 10,1978 Maryland Usual Residence of Decedent Maryland 10a State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d Inside City Limite 1 ☐ Yes 2 TNo Director Maryland Queen Annes Stevensville 94 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Dodd's Lane Funeral 21666 USA 14. Race - American Indian, deeth 12. Was Decedent Ever in U,S.
Amed Forces?
1 Yes 2 2 No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. ther then "naturel", or ite 14 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Clothing Store 12 Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: if frem 27 is marked other eny injury or other treumatic event once. Be Lamont Darnell Wright, Sr. Erica Rene' Courtney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Erica Courtney, Mother Erica Courtney, Mother 107 Dodd Ln., Stevensville, Maryland 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Batts Neck Cemetery 2/4/2000 Stevensville, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 unce 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 30min disease or condition resulting in death) Examiner induced e lectusly te Abhamaby 48 home Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Focal Segnental gloneryosclerosis Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23h. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 Yes 2 ₽No Division of Vitai 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To 1 Yes 2 No Other: 4 Nursing Home 6 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After or Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours effected.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 442587 1/31/00 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 12 oad Centreville MD 21617 Russell Schilling DO. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Deeth Chambers 9:30pm Keo ameo 02 2000 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number 4c. County of Death Chestertown Nursing & Rehabilitation Ctr. Kent County Chestertown 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthptece (State or Foreign Country) 1XM 2□ F Months Deys Hours Min. Yrs. 220-30-7078 Usuel Residence of Decedent 68 August 31,1931 Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits MXYas 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 415 Morgnec Rd. 21620 12. Was Dacedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Bteck, White, etc. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Merried 2 Merried 1 Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Dacedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Getty's Oil 6th Service Attendant 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) George J. Chambers Pauline Hackett 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Portia Turner 502 Cannon St., Chestertown, MD 21620 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Deta 1 XX Burial 2 Cremation 3 Ramoval from Stata 2-12-00 Butlertown, MD 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Olive Cemetery 21. Signature of Funeral Septoe Licensee 22. Name end Address of Fecility Bennie Smith Funeral Home P.O. Box 1687 Easton, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each lina. Approximata Intervat Between Onset and Deeth tmmediete Ceuse (Final disease or condition rasulting in daath) 4 wede neumonia Dua to (or as a consaquance of): Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or thjury that initiated events rasulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to complation of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicat exeminer? 28. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1□ Yas 2 No 1 ☐ inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of

**Physician** /Medical Examiner Examiner Physician/Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

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Pages 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23.

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permit. Pages Department of Important: If it any injury or o

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(Check only one)

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29a. Certifier

5 Pending

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death.

The law requires that the death certificate be executed or Attending Physician: To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

State Registrar

29c. License number

Chestertoure,

12 Certifying Phyatcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

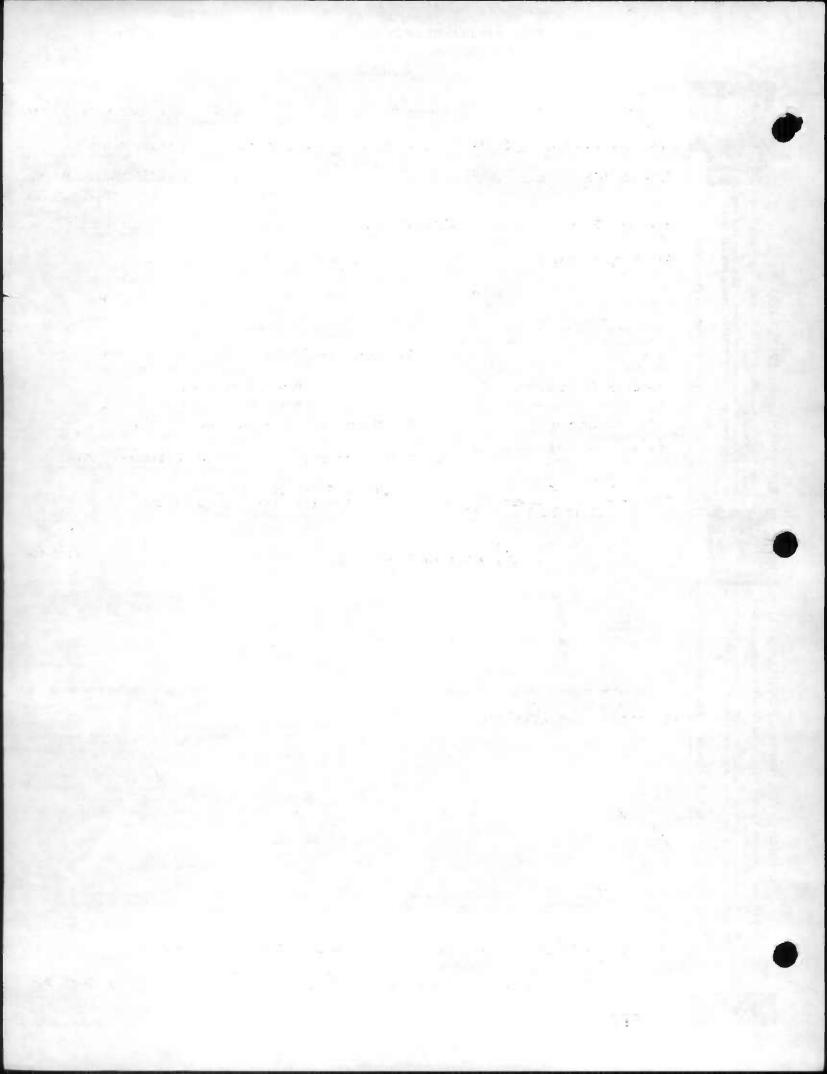
28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

30. Name end eddress of person who complated causa of daeth (ttem 23e) (Type, Print)

32 Registrer's Signetura

31. Dete filed (Month, Day, Year) FEB 0 8 2000

28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0334 BRIDGETTE (BRIGGETTE) 1543 RUARY 16,2500 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 2⊠ F Months Days Yrs. 36 1963 CLERMONT, FL. 266-73-8384 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Barclay Street 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1. Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade housekeeper domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Albury Dorothy Mack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MIAMI, FL. Willie Albury/father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DXBurial 2 Cremation 3 Removal from State OAK HILL CEMETERY 2-29-00 CLERMONT, FL. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licens Jolley Memorial Chapel To not enter the mode of dying, such as cardiac or respiratory arrest, one cay in on each line. 21801 23a. Part1. Eriter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death sleatt Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Delaturat

iclan end buriel-transit physician the burie 980 signed by the a of Vital Records. page 2 or Attending Physician: director. this Division death. within 24 hours after deat To the Funeral Director:

Examiner Physician/Medical þ Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

Director

Funeral

by

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**Funeral** 

Director

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6 23a

"natural", or

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Maryland

Baltimore,

Pages 1 and 2 should be nent of Health and Mental

nt of Health a If Nem 27 is or other trai

**Physician** 

/Medical

Examiner

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BRIDGEHE

5 Pending investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be 4 ☐ Hornicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

SALISBURY MS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and ottle of pertifier s of person who completed cause of death (Item 23a) (Type, Print)

D25209

29d. Date signed (Month, Day, Year) 2/14/00

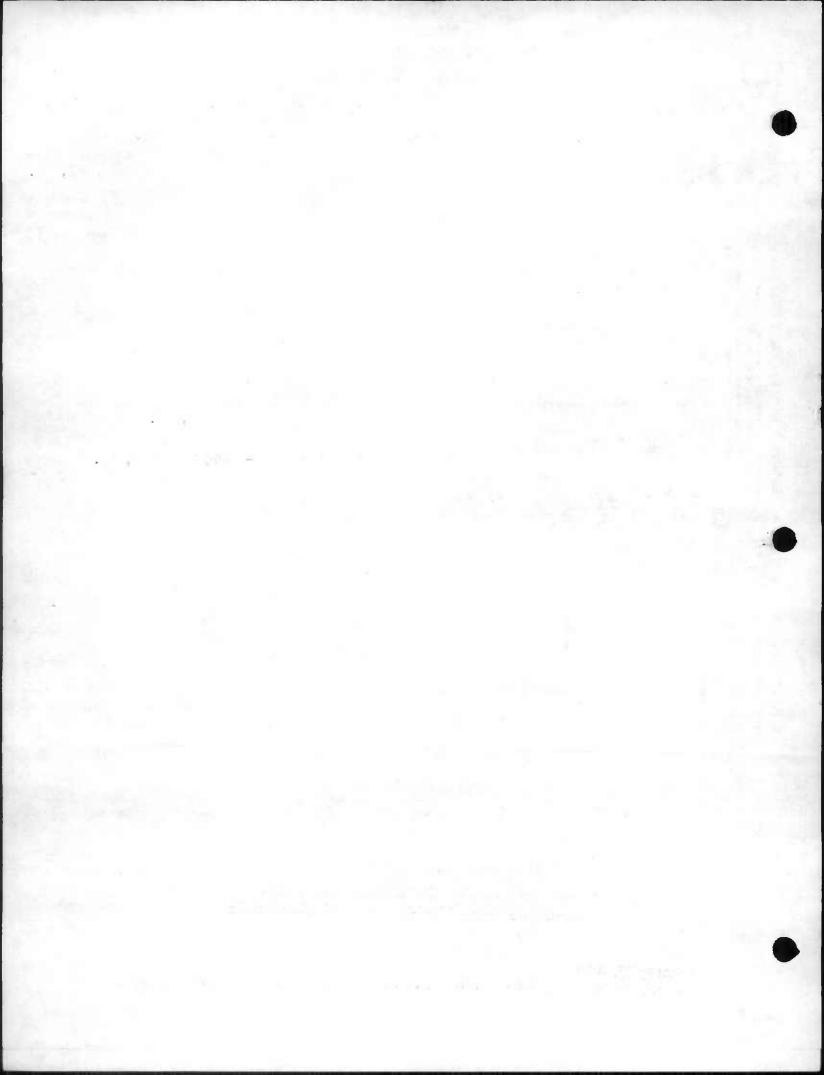
M.D. 1315 6. DIVISION John 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Hospital

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	Plea	ase Type or State o		and / Dep	partme	ent of F	Health a	and N			_egit	ole.	06471
				U	ertifica	ate or	Death			Reg. No.			
1. Decedent'a Na		ic it							2. Dete of D Month			Year	3. Tima of Death
SANDR	LA C	CAROL	CROSSO	)N					FEB.	7 2	2000		2:50 PM
4e Facility Name	(If not institution	n, give street and nu	mber)			1			Location of Dea	ath 4c.		of Death	
HOSPIC	E HOUSE							STON		TALBO			
5. Social Security		6. Sex 1  M 2  F		yrs. last birthde	Month	der 1 Yeer na Days		24 Hrs. Min.	8. Date of B	lirth Dey, Year)		Coun	olaca (State or Foreign
178-36-2		1□ M 2∏.F	56	Yrs.	Yrs.				MAY 4	, 1943	3	PEN	NSYLVANIA
Usual Residence 10a. State	of Decedent	,	100	. City, Town or	Location							1	0d. Inside City Limita
TOB. OIBIO	100. 000111		100.	Oky, Town C.	LUCATION								Was 2 No
MD		LBOT		EASTO									
10a. Street and N					10f. Zip Code							Vhat Coun	ary?
1070	WASHING	GTON ST.,	APT. J	1608	2	21601				US	SA		
11. Meritel Status		12. Was Dec	cedent Ever In	1 U,S. 11	3. Was Dec	cedent of h	Hispanic Original	gin? (Sr	pecify Yes or No Rican, etc.)	Vo- 1		a - Americ k, White,	ean Indian,
	arried 2 Merr	ried 1 ☐ Yes			2XQNo			/ I them is a market		Specify:		HITE	
(So		nt'a Education est grede completed)		16a. De	cedent's Us	sual Occur	pation during most	t of wor	ting	16b. Kir	nd of Bu	siness/Inc	dustry
	econdary (0-12)	College (		life	e. DO NOT	use retire	id)	Or Work	ung				
12		-0-		H	HOUSEW	/IFE				OWI	N HO	ME	
17. Fether's Nemo	e (First, Middle,	Last)					18. Mothe	er's Nam	ne (First, Middl	le, Maiden (	Sumame	e)	
MILTON	L. MART	IN					ROM	MAIN	NE McCO	LLUM			
19a. fnforment'a l		ship <i>(Type, Print)</i> ARTY / DAU	IGHTER	-1//					GHMAN,	7711		State, Zip	Code)
20a. Method of Di	Disposition	3 □Removal from	200	b. Placa of Dis cemetery, cr HESAPEA	sposition (No	Veme of or other ple	ece)	1	Dete 2-9-00	20c. Loc	cation - (	City or To	own, Stete
21. Signature of F	THU R	r complications that of only one cause on e	CFR caused the deach line.	Co	FELLO 200 S enter the mo	OWS, I	RRISON	NBEI N ST cardiac	C., EAS'	TON, 1	-		HOME, P.A.  Approximate Interval Between Onset and Death
Immediate Ceuse disease or condit resulting in death	ition	a. 54	aphy/	loss ce i			ocar	-d.	itii				2 weeks
			Due to	ofor as e cons	sequence of	A):						1	
		<b>b</b>	rect	COLH	nin	>						1	
Sequentially list of any, leeding to cause. Enter Unc Cause (Disease of that initiated even resulting in death	immediate derlying or Injury nts	c		o (or es a cons									
Part ff. Other sign	nificant condition	d	eath but not	resulting in the	e underlying	cause gi	ven in Part	20			uae con ≥No		o the cause of death?
ch	ervniz	male	intri	hni			WW.			es an autop rformed?	sy	av	ere autopsy tindings eilable prior to empletion of cause death?
									10	Yes 25	No	10	☐Yes 2☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

To Be Completed by Funeral Director

**Funeral** 

Director

Medical Certification: To Be Completed by Physician/Medical Examiner within 24 hours after daath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Sequentially if any, leedin cause. Ente Cause (Dise that initiated resulting in d Part ff. Other

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25. Was case referred to medical	26. Placa of Death (Check only one)										
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing	Home 5 Residence 6 Bother (Specify) HUSA1€-L								
27. Manner of Death  1 Datural 5 Pending 2 Accident investigation		28c. Injury et Work? M 1 Yes 2 No	28d. Describe how Injury occurred								
3 Suicide 6 Could not be determined		et, factory, offica	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
20e Cartifier 18 Cartificing Dh	unfolon. To the best of my knowledge, death	annured at the time, data and place	and due to the serves/s) and manner as stated								

29a. Certifier (Check only one)		examination and/or inve		d due to the cause(s) and manner as steled. at the time, date and place, and due to the ceuse(a
29b. Signature an	d title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

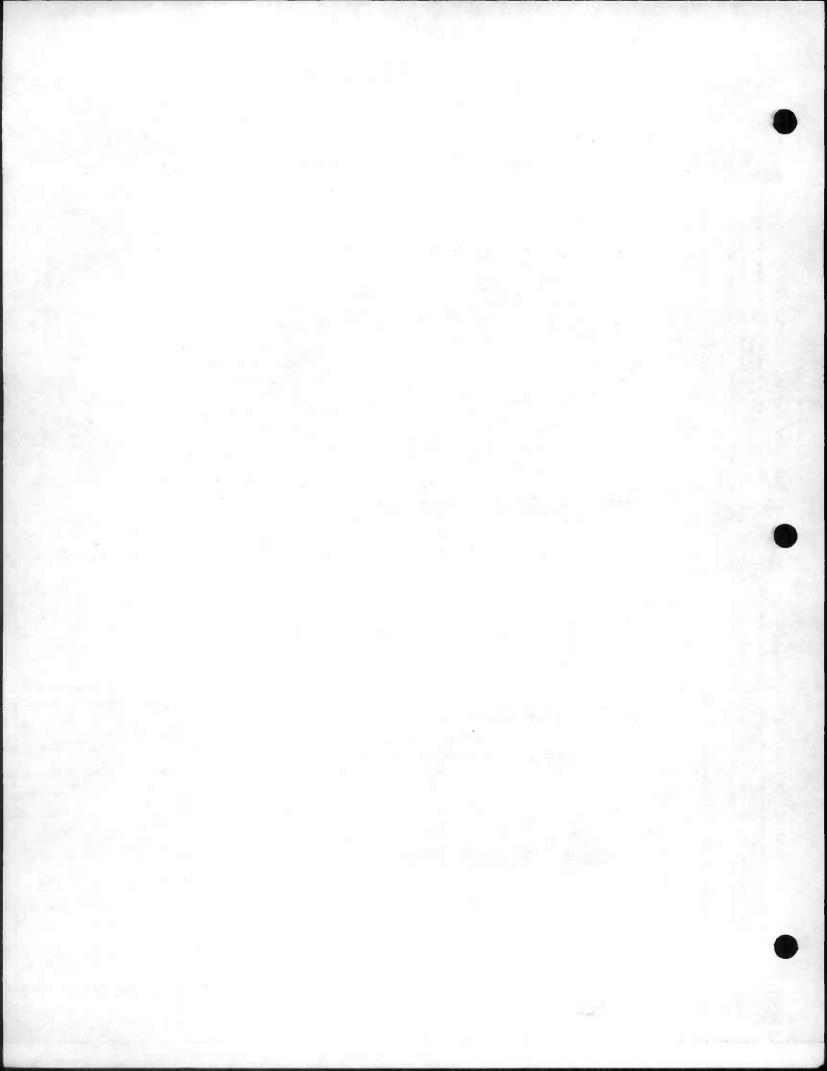
ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar

31. Dete filed (Month, Dey, Year) FEB 1 0 32. Registrar's Signature

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Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🏻 🦳 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year C. DOTSON JR. 28 VERNON 2000 JAN 8:20 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death LORIAN NURSING COLUMBIA HOWARD HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1⊠M 2□ F 76 228-14-8813 1923 Virginia March 22, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Elkridge 1 X Vas 2 No Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21075 6391 Rowenberry Drive Apt. 408 12. Wes Decedent Ever in U,S. Armed Forces? XX Yes 2 □ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1□ Yes ŽŽ No Specify: Specify: White ₩idowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Metro Transit System Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Georgia Walker Vernon C. Dotson 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 536 Higgins Drive, Odenton, Maryland, 21113 Vernon C. Dotson, III/Son 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date XX Buriel 2 Cremetion 3 Removel from Stete Meadowridge Memorial Pk. 2-1-00 Elkridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland, 20707 23a. Part1. Enter the drawn, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart, failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) 3 YEARS · ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence ot). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were eutopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piaca of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. Stete

MD

**Funeral** 

Director

t then "netural", or items 23s or 28s-f show the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelih and Mental Hygiene. Important: if Item 27 le marked other then "natural", or ite any fnjury or other traumatic event, trained as Examinancia.

altimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner Physician/Medical should be det Completed by Be Certification: To After

P.O. Box 68760. Records. Division of Vital or Attending Physician: n 24 hours after death.

The Funeral Director: After close the filled in by the fur To the Hosp within 24 hos To the Fune completely fi

COPD 25. Was case reterred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of tnjury - At home, term, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyelctan: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifler (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

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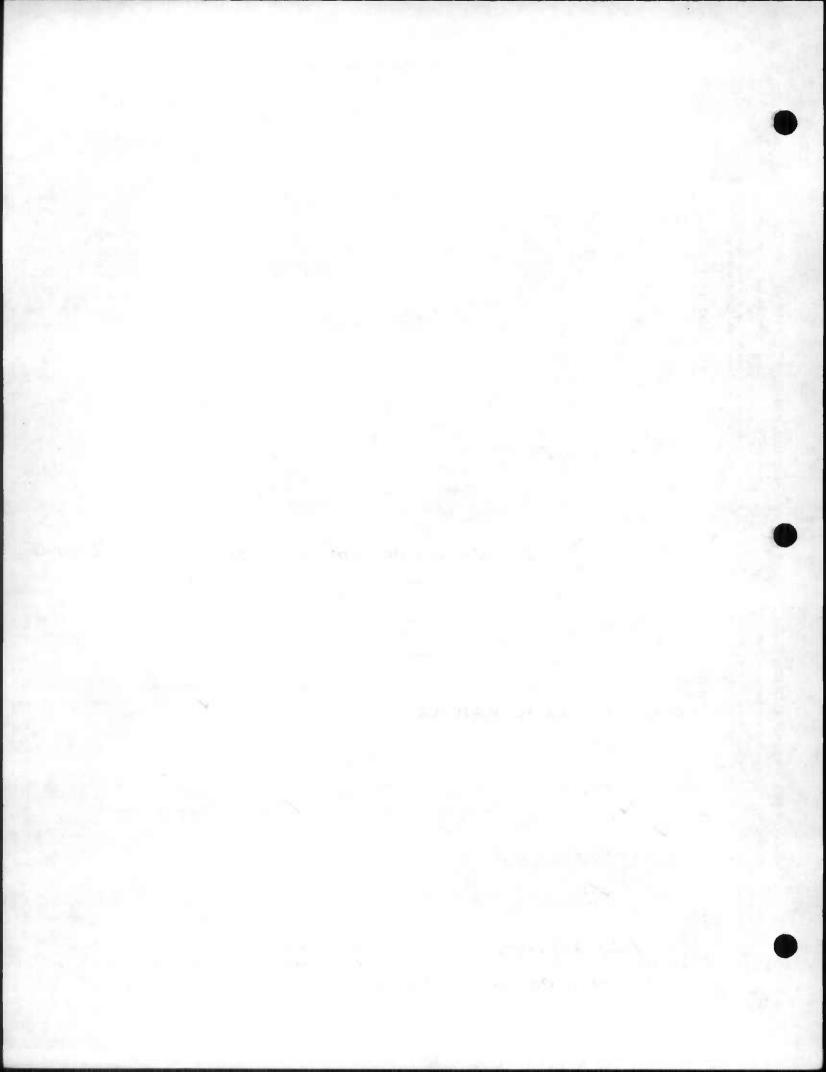
30. Name and address of person who completed cause of death (Item 23s) (Type, Print) BERNARD P. FARRELL MD

11055 LITTLE PKWY, COLUMBIA, MD 21044 PATILXENT

State Registrar

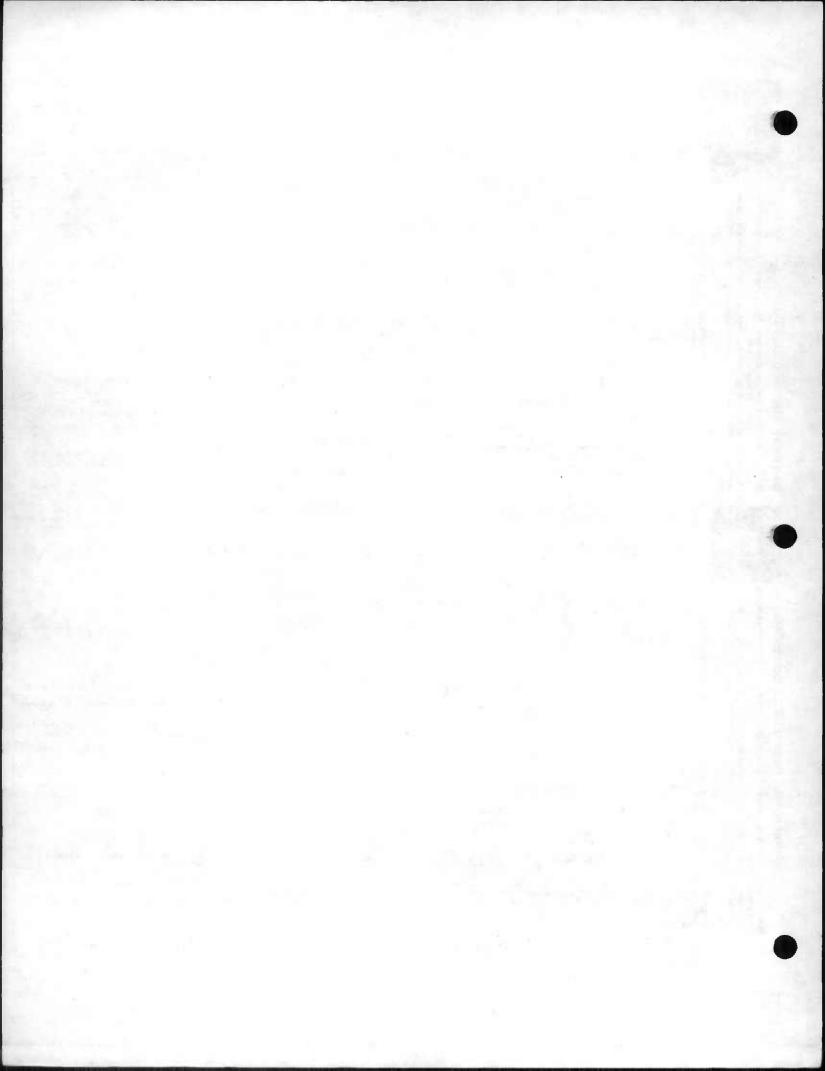
Medical

31. Date filed (Month, Day, Year) FEB 0 1 2000 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dev Month Year Physician Virgil Dols February 06 2000 11:00 A /Medical 4a Facility Name (If not institution, give street and number)
Fallston General Hospital 4b. City, Town, or Location of Death Fallston 4c. County of Death Examiner Harford If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 30,1907 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 477 34 3801 1€M 2□ F 92 Yrs. Director Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Forest Hill Maryland Directo "natural", or Items 23a or 25a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 109 Forest Valley Drive 21050 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ward of Health and Mentall Phylines. entil fleen 27 is marked other than "natural; or he sury or other traumatic event, the Medical Estation. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pharmacist Pharmacy 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) å Henry Dols Helena Halleran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 729 Chestnut Hill Road, Forest Hill, Maryland Tom Dols/ son 20c. Location - City or Town, Stare 1050 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20s. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Department of Important: If any injury or 2/11/00 Minneapolis, Minnesota Sunset Memorial Park 21. Signature of Funeral Service Ligenses 22. Neme end Address of Facility Donaldson Funeral Home, P.A. 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ELECTROLYTE 1 DAY Examiner Due to (or as a consequence of): Physician/Medical Examiner FAILURE ACUTE RENAL physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, Due to (or as a consequence of): signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director. 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending To the Hospital or Attendir within 24 hours efter deeth. To the Funerel Director: Al completely filled in by the fu deeth. 2 ☐ Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 16 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Andres Nowakowski D08096 FEBRUARY 6, 2000 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INPROW NOWAKONSKI 125 N, MAIN ST. BEZAIR, MP21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 1 2000 Registrar

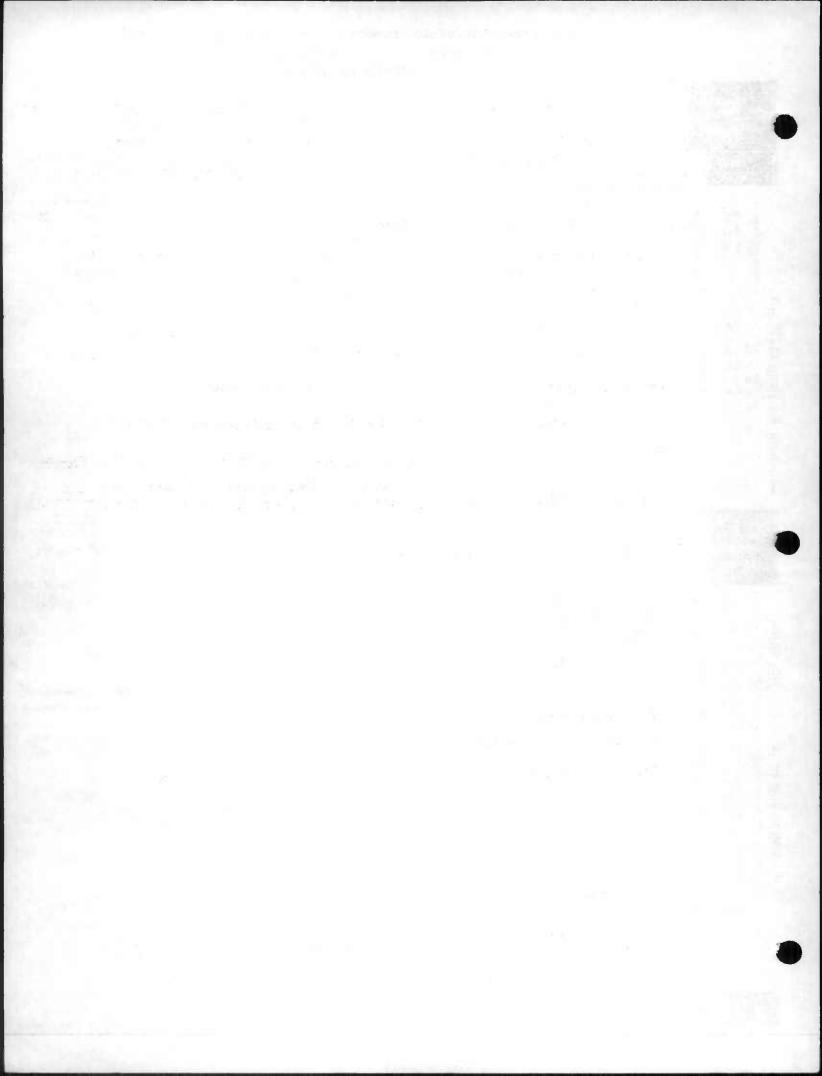
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State of Maryland / Department of Health and Mental Hygiene

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Physicia /Medic		1 Decedents Name (Cint Middle 1										
	Decedent's Nema (First, Middla, Last)  Physician						2. Data of D Month		Vana	3. Tima of Death		
Medic		Henr	y H. Geor	ie			Janua	ry 17, 2	Year 2000	905 an		
Examin		4e. Facility Nama (If not institution, gi	ve street end number)			4b. City, Town,	or Location of Dea	4	4c. County of Deeth			
		6510 Beechwood Di	cive			Colum	mbia	Howard				
Funeral Director		5. Social Sacurity Number 6. 158-09-1811 Usuel Rasidence of Decedant	177 M OFF	e (In yrs. last birthda 81 Yrs.	y) If Undar 1 Yo Months De		Hrs. 8. Date of 8 (Month, E	bay, Yaar) 5, 1918	9. Birthr Cour Pen	placa (State or Foreign ntry) insvlvania		
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23a or	ai D	6510 Beechwood Dr	ive		21	046		Unit	ed St	ates		
5 22	by Funer	11. Marital Status  1 □ Nevar Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedant I Armed Forcas? 1 ☐ Yas 2₹ N tf Yes, Give Yaar or Dates:		8. Was Decedant tr Yas, specify 0 1 ☐ Yas 2]☑		? (Specify Yas or N uarto Rican, atc.)	Io- 14. Ra Ble Speci	can Indian, etc.			
72 hours		15. Decadant's E	ducation	16a. Dec	edant's Usual Oc	cupetion		16b. Kind of f				
c 4	Completed	(Specify only highast gi	ada com <i>plated)</i> Collaga (1-4or 5	i+)	DO NOT usa re	ona during most of tired)	working	Johns	-	ns sics Lab		
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d 2 should be filed the and Mentel Hygis 7 is marked other traumatic event, in	To Be	Clarence V. Georg	e			Floren	ce Horsei	field				
shou and N		19a. Informant's Name/Relationship	(Type, Print)	19b. Me	iling Addrass (Str	reet and Number o	r Rural Routa Num	ber, City or Town	n, Stata, Zip	Coda)		
1 end 2 Health e em 27 is		Sylvia J. George/	Wife	651	0 Beechw	ood Driv	e Columbi	ia, MD 2	1046			
862		20a. Mathod of Disposition  1 □ Burial 2 □ Cramation 3 [ 4 □ Donation 5 □ Other (Speci	f place)	Date	20c. Location							
permit. Pege Department of Important: If any injury or		4 Donation 5 Other (Specify)  21. Signatura of Funeral Sarvice Licensaa  22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Ho 4112 Old Columbia Pike Ellicott City										
Physician /Medical Examiner		23e. Pert1. Enter tha disaasa, or con shock, or heart feilura. List only Immadiata Ceusa (Final disaasa or condition rasulting in deeth)	e.	hychatur	ntar tha mode of	dying, such es car	diec or raspiretory	errest,		Approximate Interval Batwaan Onset end Death  2 muths  2 muths		
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artificate be ing physicia e es the bur	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated evants resulting in death) Last	C	Dua to (or as a c <i>ons</i>	equance of):							
deeth deeth	Physician/	Part II. Other algnificant conditions	contributing to death bu	ut not rasulting In tha	undarlying cause	givan in Part I.	23b. Die	d tobacco use c	ontributa t	o the cause of death?		
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requir seen s hould	þ	atrial Ab	nelation	r			24e. Wa	is en autopsy formed?	av	ara autopsy findings ailabla prior to empletion of cause		
	Completed	hyprothyro	edism				1	Yas 2 🕱 No	of	death? □Yes 2□No		
Physician: T this certificat ral director, pr	Be	25. Was casa refarred to medical axaminar?				26. Place of	Daath (Check only	ona)				
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To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affe completely filled in by the fune	29a. Cartifiar (Check only one)  1 **Certifying Physician: To the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred at the time, data compared to the best of my knowledge, dasth occurred to th						lace, and dua to the occurred at the time	e cause(s) and n a, data and place	nannar as s , and dua t	stated. o tha cause(s)		
within To th	29b. Signatura and title of certifiar / 29c. Licansa number							29d. Data sign	ed (Month,	Day, Year)		
		) am Oll	line my		1)	21461		Januar	y 17,	2000		
43		30. Nama and addrass of person who	complated causa of de	aath (Item 23a) (Type	e, Print) Dr f	entry moor	d Z	045				
Stat Registra		31. Data filed (Month, Day, Year)  JAN 18		ar's Signatura	6 1	a.V.						



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4 PM Graue 03 2000 eu February
4b. City, Town, or Location of Death an /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Hospital Prince George's Regional Laurel Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2XF Yrs. **Director** 216-30-3858 Nov 06, 1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Howard Laurel Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10590 Scaggsville Road 20723 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer a Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Estimation page. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Melden Surneme) 17. Father's Name (First, Middle, Last) Joseph Harding Lottie Leisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary CHris Grauel/granddaughter 10590 Scaggsville Road, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Lutheran Cem. 2/6/00 Fulton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 curcomplications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, and only one ceuse on each line. Approximete Interval Between Onset and Death 23a. Part1. Enter the distriction shock, or heart fall units **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia Examiner Physician/Medical Examiner Inocavalra attending physician end for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 1 ☐ Yes 2 No 3 Probably 4 Unknown LOVONAVy artery discuse by 24b. Were autopsy findings available prior to 24e. Was an eutopsy performed? Completed s need heart failure completion of cause of death? hes eged /tnemia 200 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Who After this funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 TYes 2 No investigation 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide filled in 29a. Certifier edicai

The law requires that the death certificate be executed Box 68760. Division of Vital Records, Physician: or Attending deeth. a after deeth within 24 hours a To the Funeral C completely filled

with the Maryland

death

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only

29b. Signature and title of certifier

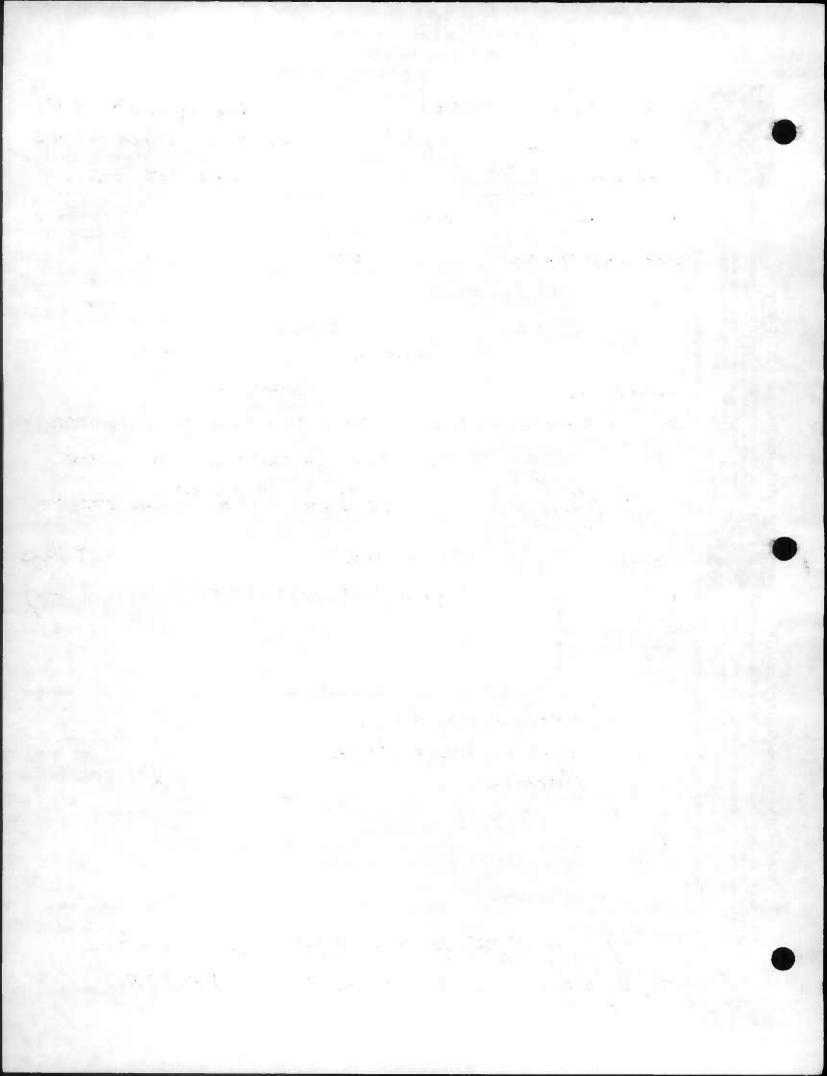
29d. Date signed (Month, Day, Year)

29c. License number

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Laurel MD 20707 Timothy D. M. (31. Date filed (Month, Day, Year)
FEB 0 7 2000 Prince George St. 321 32/Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 06476

		1. Decedent's Name (First, Middle	Last)			tificate			2. Date of De	Reg. No.	000	3. Time of Death	
Physici /Medi		John Douglas	Garner						Februa	ry 7, 20	OQQ.	6:30 pm	
Examir		4e. Fecility Neme (If not institution,	give street end numbe	r)				4b. City, Town, or I					
		Laurel Regiona	l Hospital					Laurel		Princ	ce Geo:	rge's	
Funeral Director		5. Social Security Number 540–48–0147	6. Sex XM 2□ F	Age (In yrs. 56	lest birthday) Yrs.	If Under 1 Montha	Year Days	If Under 24 Hrs. Houra Min.	8. Dete of Bir (Month, Di Dec. 7	iy. Year) 1943	9. Birthplai Country LOW	ce (Stete or Foreig a) a	
DUE *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							
r 28a-f show	0		George's	-	urel				10d. Inal				
28e	rect	10e. Street and Number				10f. Zip C	ode			10g. Citizen of	itizen of What Country?		
23a or	io le	8406 Snowden C	aks Place			207	80			U.S.A.			
or items	by Funeral Director	11. Meritel Stetus  1 Never Married 2 Merrie  3 Widowed 4 Divorced	12. Waa Deceder Armed Forces MYYes 2 E If Yes, Give Yeer or Detes	3? ] No		Ves Decede Yes, specif		lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Rac Ble Specify	0.		
natural',		15. Decedent	Education	•	16e, Deced	lent's Usual	Occur	etion		16b. Kind of B	Whi:		
	Completed	(Specify only highest Elementery/Secondery (0-12)	grade completed)  College (1-40)	· E · \				etion during most of word d)	king				
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marked marked	To Be	John Wilburn C						Patric	ia Hard	in Boyd			
bue u		19a. Informant'a Name/Reletionsh	,					end Number or Ru					
Health sm 27		Regina J. Cody  20a. Method of Disposition	/ spous					Oaks Pla		20c. Location	-	20708	
rimer rimit:		1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	8	Metro Crematory, Inc.				eb. 12, 2000	Catons		Marylan	
Depar Import		21. Signature of Funeral Service L	Confide					Funeral t Avenue			land	20707	
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/Medical Examiner	disease or condition acusto caredi onul monardy arrest											- 2 day	
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sicia e bur	ca	Cause (Disease or Injury that initiated events	c	Due to (or es e consequence of):									
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endin r use	and		d. Lendi	IIIDUL	ricien	C y					i		
he att	sici	Part II. Other significant condition	s contributing to death	but not resi	uiting In the ur	nderlying cau	ise giv	ren in Pert I.	23b. Did	tobacco use co	ntribute to ti	he cause of death	
requires the trie death certificate of executed een signed by the attending physician and hould be detached for use as the buriel-transit	by Physician/	diabetes melli	tus						10	Yes 2□No	3 Probe	bly 4 Unkno	
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is certificate director, pag	Be	25. Wes case referred to medical examiner?						26. Place of Dee	th (Check only	one)			
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When	inol .	27. Menner of Death  1XXIIeturel 5 ☐ Pending		ley Year)	28b. Time of Injury		. Injur Wor		28d. Describe	how injury occur	red		
within 24 hours efter death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investige 3 Sulcide 6 Could no 4 Homloide determin	tition M 1 Yes 2 No					Yes 2 No	28f. Location ( City or To	Street end Numb wn, Stete)	per or Rural F	Route Number,	
n 24 hour e Funera detely fille	edical (	29e. Certifier (Check only one) 1 Certifying 2 Medical E	ne, dete and place plnion, deeth occu	, and due to the rred at the time,	cause(s) end mo dete end place,	anner as atat and due to th	ed. ne cause(s)						
Within To the comp	Σ	29b. Signeture end title of certifler				29c. (	Licens	e number		29d. Dete signe	d (Month, De	ly, Year)	
,		1 Padmaga					24	1174		Februar	cy 8,	2000	
15		30. Name and address of person was Padmaja S. Uda					Con	ite 380	Laurel	Marenla	20	707	
							Lalire -	M2 L() 131	101 211				

Piease Type or Print in Black Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Month Physician Sr. 5:38 PM GREETZ 2000 JOEL FEB 10 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COLUMBIA GENERAL HOWARI COUNTY HOSPITAL HOWARD 7. Aga (In yrs. last birthday) | ff Under 1 Year | ff Under 24 Hrs. | 8. Data of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days 18 M 2□ F Yrs. 219-01-3992 91 Director March 12, 1908 Tennessee Usual Residence of Dacedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2010 Director Ellicott City Maryland Howard must be notifi-10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 5008 Worthington Way 21043 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puerlo Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give 1 Nevar Married 2 Married à 1 Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 € Divorced Year or Dates white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Cottege (1-4or 5+) Stationary Engineer Paper Mill 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Nem 27 is marked ort lary or other traumatic even Be Joel S. Greer Lucy J. Chaney 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce DeBoy / daughter 1810 Arbutus Ave. Baltimore, MD. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Febata 15 ty Buriat 2 □ Cremation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) 2000 Meadowridge Cemetery Elkridge, Maryland 21. Squature of Funarai Sarvice Licansee 22 Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 SPOION 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediata Ceuse (Finai STOOKE disaasa or condition rasulting in deeth) Examiner Dua to (or as a consequence of): PHEMMONIA MOITASIAZA + DAYS Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): 3 MONTHS DYSPHAGIA Physician/Medical the Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No CORONARY ARTERY DISEASE, CHRONK ATRIAL FIBRILLATION Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should ISCHEMIC (ARDIOMYORATHY 1 Yas 2 No 1 □ Yas 2 □ No funeral director. 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 27. Manner of Death 1 Maturai 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Panding investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled.

The law requires that the death certificate be asscuted P.O. Records, Division of Vital Attending Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

certificate

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After

Box 68760,

28a-f show

ð 23a

filed within 72 hours after

Hygiene. ther than

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altimore, Maryland 21215-0020

completely

State Registrar

29a. Certifier

(Check only one)

29b. Signatura and title of certifiar

fellow mo

JOSEPH GIBBONS MD 31. Data filed (Month, Day, Year) 32. Registar's Signeture FEB 1 1 2000

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

9501 OLD ANNAPOLIS RD.

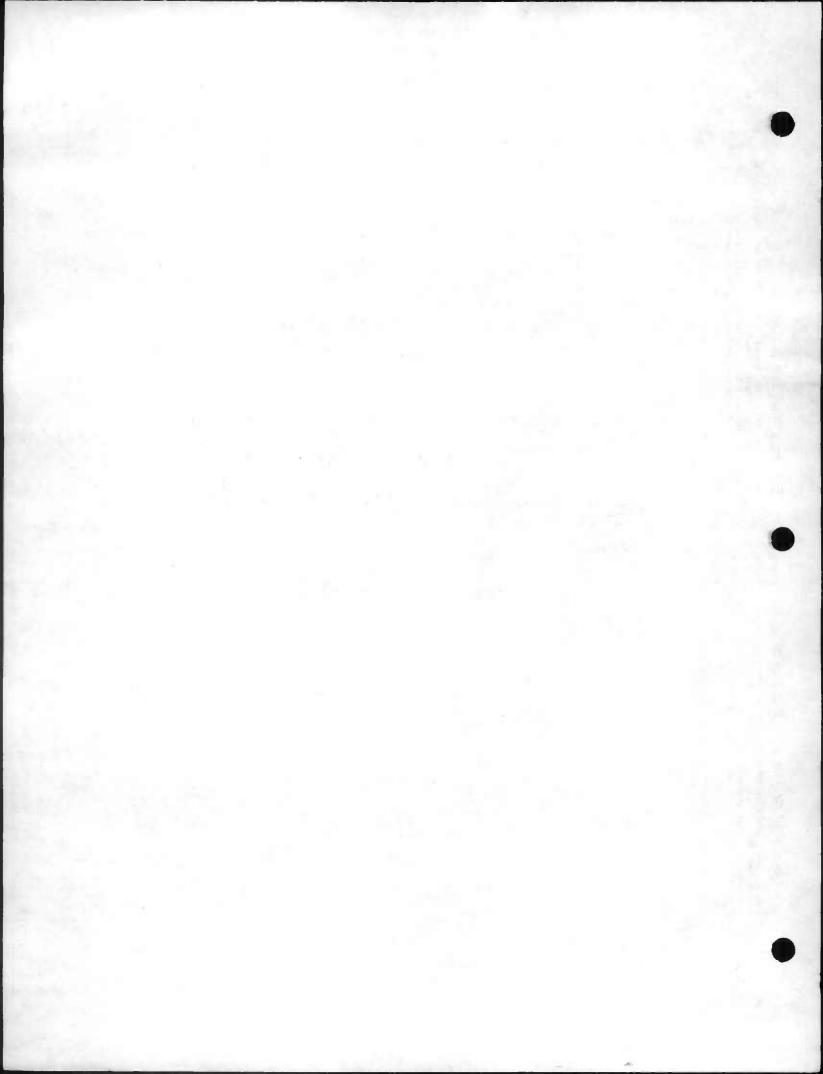
29c. License number

138296

29d. Date signed (Month, Day, Year)

FEB 10 /

ELLICOTT (ITY, MD



**Physician** /Medical Examiner

be executed

P.O. Box 68760,

Division of Vital Records.

this certificate hes

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Director: After After

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To the within 2

**Physician** 

/Medical

**Examiner** 

10a. Stete

MD

Director

Funeral

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Completed

**Funeral** 

Director

the Merylar

item 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examiner nast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygione. Important: If item 27 is marked other than "naturel", or ite, any injury or other treumatic event, the Medical Exemples.

Baltimore, Maryland 21215-0020

Examiner physician and the buriel-transit 80 USB ed by the a signed by t funeral

Physician/Medical þ Completed Be 2 Certification:

29a. Certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 25. Was cese rafarrad to medical examiner? 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Mannar of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicida

Othar: Nursing Home 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to tha causa(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of py

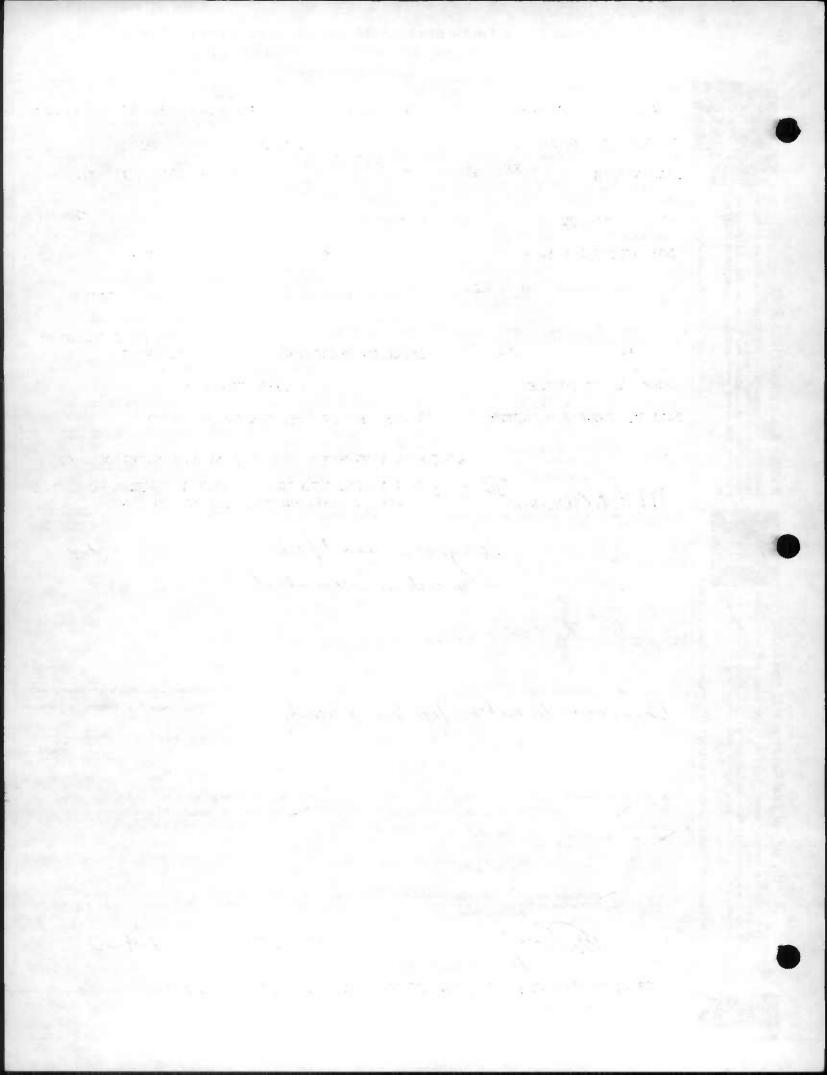
29c. License number DZ5933 29d. Dete signed (Month, Dey, Year) 2.4.00

1 ☐ Yas 2 ☐ No

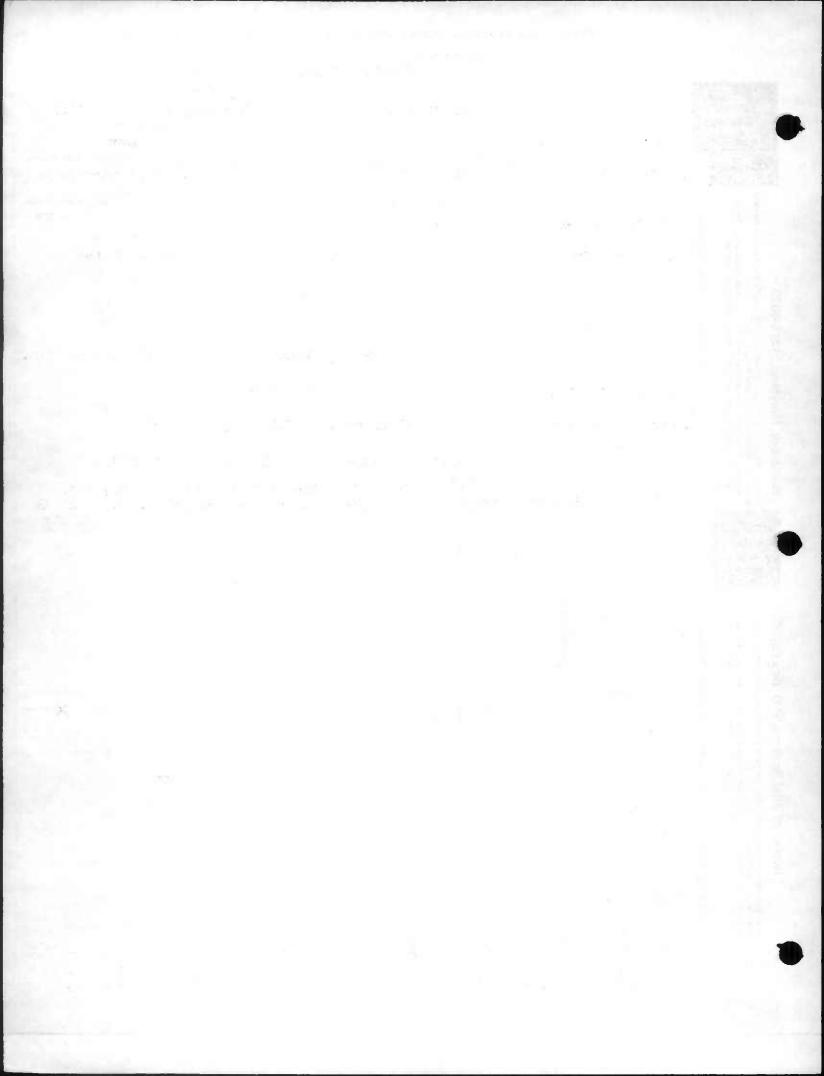
30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MICHAEL D. CROWLEY, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Date filed (Month, Day, Year)

State Registrar



					Certi	ficate of	Death		Reg. No.	00	4/9
hysiciar /Medica	al		Catherine		lughes			2. Data of De Month Februar	y 4, 200	Yaar 00	Time of Death  11:30pn
xamine	_	4a. Facility Name (If not institution,		er)			4b. City, Town, or				
neral		Lorien Nursing H 5. Social Security Number		Age (In yrs. la	st birthday)	If Undar 1 Year	Columb  If Under 24 Hrs			ward 9. Birtholace	(State or Foreign
ector	-	179-10-6690 Usual Residence of Decedent	1□ M 2 <b>⊠</b> F	91	Yrs.	Months Days	Hours Min.	June 2	22, 1908	Pennsy	(State or Foreig Ivania
an pa		10a. State 10b. County		10c. City,	Town or Local	tion				10d. lr	side City Llmit
notified	cto	Maryland Howar	d	Co	olumbia					1	Yes 2 N
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Tunk	era	9237 Silver Sod	40 Was Daniel	-4 Francis II 0	40.14/	2104		D14-14		State	
0 5	by Funeral Directo	11. Marital Status  1  Naver Married 2  Married  3  Widowed 4  Divorced	12. Was Deceded Armed Force 1  Yes 2 If Yes, Give Yaar or Date	s? ☑ No	lf Y	as, specify Cuba	dispanic Orlgin? (S an, Maxican, Puar Specify:	to Rican, etc.)		e - Americen In k, White, etc. Whit	
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Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)			during most of wo d)	ики			
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2 0	Be	17. Father's Name (First, Middle, La							, Ma <i>iden Sum</i> am	e)	
metic	2	Francis Gallaghe  19e. Informant's Name/Relationship			105 Mallina	Address (Chrost	Elizabe	th Henle	-	C++- 7:- 0-4	- 1
trau		Winnie Moore/Nie					od Colu		_	State, Zip Coo	9)
other to	_ h	20a. Method of Disposition	ce	20b. Pla		ion (Name of tory or other place		Date Date	20c. Location -	Olty or Town, S	State
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eny injury or		21. Signature of Funaral Sarvice Lic		101044	22. N	lame and Addre	ss of Facility				
eny Ir		> Shema Col			Har	ry H. W.	itzke's				
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page C	ဂ် ပ							10	Yes 2 No	1 ☐ Yes	2□ No
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	5	1 Natural 5 Pending 2 Accident investigat	ion	Day Year)	28b. Tima of Injury		rk? Yes 2 □ No		how injury occurr		
	S			Injury - At hore	ne, ferm, street	t, factory, office		28t. Location (	Street and Numbe wn. State)	er or Rural Rou	ite Number,
by the funeral di		3 Sulcide 6 Could not determine	ed 28e. Place of building,	etc. (Specify)			_				
by the funeral di		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not determine  29a. Certifying	Phyaician: To the beaminer: On the basis	etc. (Specify) st of my knowl	edge, death oon and/or inves	ocurred at the tir	me, date end place	e, and due to the urred at the time,	ceuse(s) end me	nner es steted and due to the	cause(s)
by the funeral di	edical	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not determine  29a. Certifying	Phyalcian: To the be	etc. (Specify) st of my knowl	edge, death oon and/or inves	occurred at the tir tigation, In my o	ppinlon, death occi	e, and due to the urred at the time,	ceuse(s) end me	and due to the	cause(s)
pletely filled in by the funeral di	edical	3 Suicide 4 Homicide  6 Could not determine  29a. Certifier (Check only)  2 Medicat Ex	Phyaician: To the beaminer: On the basis	etc. (Specify) st of my knowl	edge, death oon and/or inves	tigation, In my o	ppinlon, death occi	e, and due to the urred at the time,	ceuse(s) end me date and place, a	and due to the	cause(s)
by the funeral di	Medical	3 Suicide 4 Homicide  6 Could not determine  29a. Certifier (Check only)  2 Medicat Ex	Phyaician: To the beaminer: On the basis	etc. (Specify) st of my knowl of examination steted.	n and/or thves	29c. Licens	pinlon, death occurse number	e, and due to the urred at the time,	ceuse(s) end me date and place, a 29d. Date signed	and due to the	cause(s)



State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 8 0

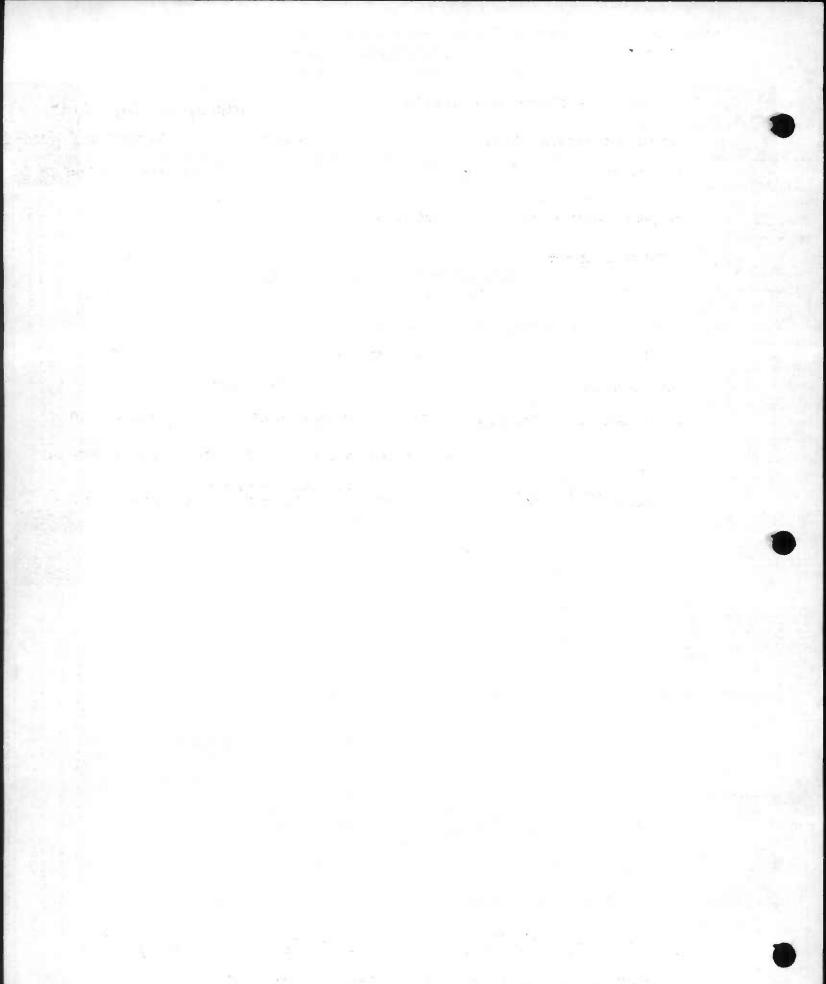
				Cei	tificate	of	Death			Reg. No.		0 7 0 0		
<u>.</u>	1. Decedent's Neme (First, Middle,	Last)							2. Date of De Month		Year	3. Time of Death		
Physician /Medical	PAUL GIL	BERT I	HARRING	TON					FEB.	8 200	0	8:30 AM		
Examiner	4a Facility Name (If not institution, 29262 HEWORTH R						4b. City, To		ocation of Deat		y of Death			
Funeral Director	5. Social Security Number 028-12-4778	Sex 7. A	ge (In yrs. last i	birthday) Yrs.	If Under 1 Months D	Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da MAR. 2	rth ay. Year) 6,1920	9. Births Coul MAS			
7 .	Usual Residence of Decedent													
with the Maryla or 28s-f show be notified at Director	MD TAL	ВОТ	10c. City, To	EAST						10d. Inside City Limits 1 □ Yes 2 □ No				
	10e. Street and Number	010			10f. Zip Co					10g. Citizen of		ntry?		
era ma	29262 HEWORTH R	12. Was Decedent	Ever in U.S.	13. 1	Vas Deceden			igin? (Sp	USA n? (Specify Yes or No- Puerto Rican, etc.)  14. Race Blec			can Indian,		
ours after death val', or leans 23 Examiner must by Funeral	1 Never Married Marrie 3 Widowed 4 Divorced	Armed Forces?	No		f Yes, specify				Rican, etc.)	Speci	ock, White,	etc.		
72 h hantu Scall Stad	15. Decedent's (Specify only highest	Education		a. Deced	lent's Usual C	ccup	ation during mos	t of work	ina	16b. Kind of 8	Business/In	dustry		
ed within 72 ho ygiens. ver than "natur ft, the Medical. Completed	Elementary/Secondery (0-12)	College (1-4or	5+)	iife. DO NOT use retired) MODEL MAKER			· Or Work	a ry	NAVAL	RESEA	RCH LAB			
d other avent,	17. Father's Neme (First, Middle, La						18. Mothe	er's Nam	e (First, Middle	, Maiden Suma	me)			
And Senta	JOSEPH HARRIN	GTON					LII	LLIA	N LYNCH					
N pun	19a. Informent's Name/Relationshi	(Type, Print)	1	9b. Mailir	ng Address (S	treet	and Numb	er or Rur	al Route Numb	er, City or Town	, State, Zip	Code)		
127 kg	ELMA L. HARRINGTON/ WIFE 29262 HEWORTH ROAD, EA								STON, M	D 21601				
Pages 1 in the ret. If learn ray or oth.	20a. Method of Disposition  1 \(\tilde{\Omega}\) Burial 2 \(\tilde{\Omega}\) Cremation 3 \(\tilde{\Omega}\) Removal from State  4 \(\tilde{\Omega}\) Donation 5 \(\tilde{\Omega}\) Other (Specify)									Date 20c. Location - City or Town, State 2-10-00 PRESTON, MD				
Departition of the series of t	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P. 200 S. HARRISON ST., EASTON, MD 21601													
attending physician and for use as the bunkl-transit claryMedical Examiner	Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									AL.		YEARS		
that the death co												o the cause of death		
5 60	CONGEST	TUZ HE	4RT	TA	LURC	2			10	Yes 2□ No	3 □ Pro	bably 4 donknow		
been s should						Ĭ,		8		s an autopsy ormed?	av	ere autopsy findings railable prior to empletion of ceuse death?		
The lay page 2									10	Yes 20 No	1[	☐ Yes 2☐ No		
certificate rector, pag	25. Was cese referred to medical						26. Place	of Deat	h (Check only	one)				
Z 0 0	examiner?	Hospital:	ent 2 ER/	Dutpatien	t 3□ DOA	Oth	ner: 4□ Nu	ursing Ho	ome 5,2 Res	idence 6 🗆 Ot	her (Speci	(y)		
After fune	27. Manner of Death  1 Anatural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, De	iry y Year) 28b	Time of Injury	28c.	Injur Wor	yat k? Yes 2□	No	28d. Describe	how injury occu	rred			
of or Attended after death of in by the certifical	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									(Street and Num wn, State)	ber or Run	al Route Number,		
Hospit 24 hour Funeri etely fill dical										cause(s) and n date end place	anner as s	stated. o the ceuse(s)		
To the within To the comple	29b. Signature and title of certifier 29c. License number								D	29d. Date sign				
	30. Name and eddress of person with WILLIAM S. B.	completed cause of o	leath (Item 23s	(Type,	Print)	77	7LB07	-5	7. 57	MICHAL	ELS M	2000		
State Registrar	31. Dete filed (Month, Day, Year)	32. Registr	ar's Signature	w	B.	de	parks							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Dorothy Shawblosky Herring 2144 February 2000 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Cambridge Dorchester Dorchester General Hospital 8. Data of Birth (Month, Day, Year)
April 12, 1927 If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 9. Birthplace (Steta or Foreign Country) MISSISSIPPI 7. Age (In yrs. lest birthday) **Funeral** 1□M 2\ F Yrs. 428-36-4105 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Cambridge 1 No 2 No Dorchester Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21613 US 701 Race Street Funeral 12. Wea Decedant Ever in U,S Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specity Yaa or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2X No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buaineas/Industry 15. Decedent's Education (Specify only highest grade com Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be liked w. Department of Health and Mental Hygiens important: if fleen 27 is merked other that any Injury or other traumetic. Own Home Homemaker 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be Eulla Downs John Shawblosky 0 19a. tnforment'a Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5608 Adamstown Road Adamstown, Maryland 21710 Sharon Garrett Daughter Saltimore, 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 2/15/2000 Salisbury, Maryland Salisbury Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Sarvice Ocensee 22. Nama and Address of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or reaplratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Death **Physician** /Medical Immediate Causa (Final diseese or condition rasuiting in deeth) Examiner Examiner attending physician and for use as the burial-transit certificate be executed Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseesa or Injury that initiated events resulting in death) Lest Physician/Medical Dua to (or as a consequence of) signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 do 3 Probably 4 Unknown Records, p been si Completed 24a. Wes an autopay performed? 24b. Were autopsy findings avellable prior to completion of cause of death? this certificate 1 No Yea 2 No Division of Vital 25. Was case rafarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Department 2 ER/Outpetlent 3 DOA funeral 28a. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Affer 5 Pending Investigation 1 Netural death. 1 Yea 2 No 2 Accident after death Director: / filled in by the 3 Sulcida 6 Could not ba 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide Ne Hospital on 24 hours af To the basis of examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) end menner stated. To the Hospi within 24 hou To the Funer completely fil 29e. Certifian Medical 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signad, (Month, Day, Year) 4656 00 30. Name end addrass of person who complated causa of death (Item 23a) (Type, Print) Dwayne F. Tull, M.D. 10 Aurora Street Cambridge, Maryland 21613 31. Dete filed (Month Per FEB 1 5 2000 32. Regigrer's Signature State Registrar



Phys /Me Exar

Funer Directe

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thems 23s or 28s-1 show any injury or other traumstic event, the Medical Examinar must be notified at

DIVISION of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be assected within 24 hours after death.

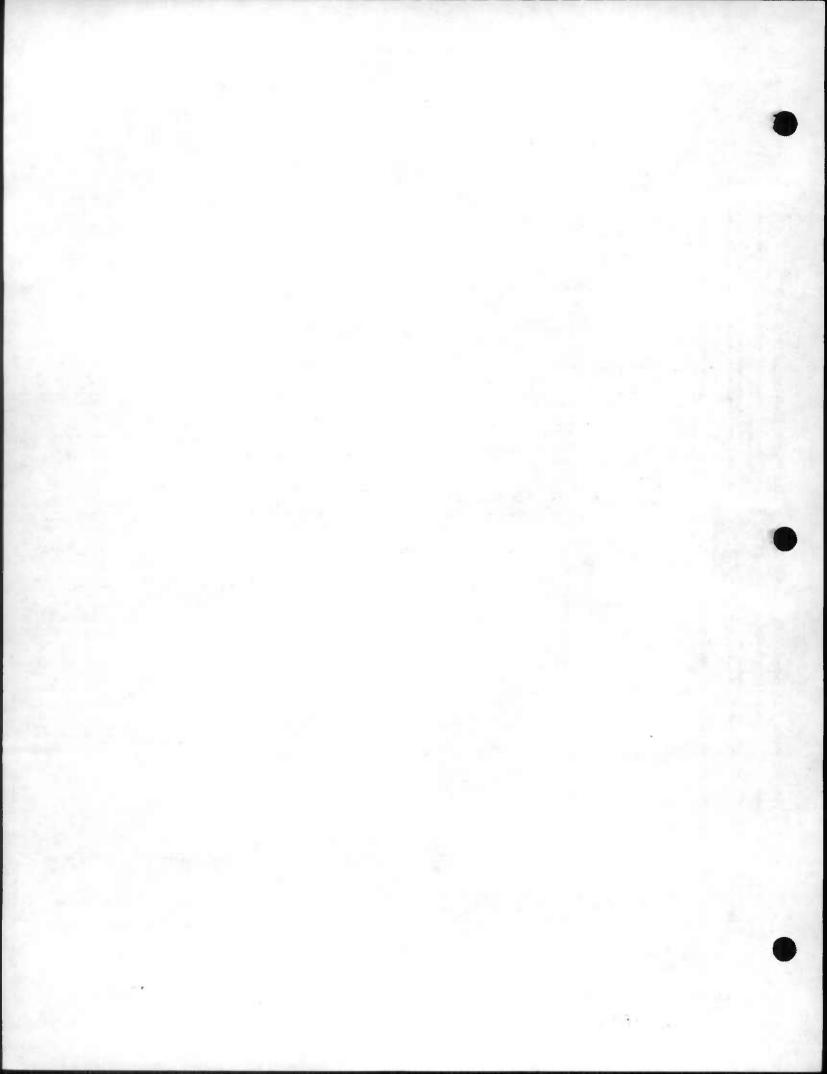
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit

Physicia /Medica

		Certific	cate of	Death		Reg. No.	06482
1. Decedent's Nama (First, Middle, Last)					2. Data of Do Month	eath Day	3. Time of De
GEORGE	E WINFRED JO	ONES				ary 3,	
4a Facility Nama (If not institution, give s			4	tb. City, Town, or L	ocation of Deal	th 4c. County	of Death
The Memorial H	- MA	1 44	Jnder 1 Yaar	Eastor		Talbo	
5. Social Security Number  213-22-7477  Usual Residence of Decedent	8. Data of Bi (Month, Di Dec. 1	ay, Year)	9. Birthplaca (State or F Country) Maryland				
10a. Stata 10b. County		10d. Inside City I					
Marriand Talbet	T47.9						1 ☐ Yes 2
Maryland Talbot  10e. Street and Number	WI	t tman	V. Zip Code			10g. Citizen of V	What Country?
8880 New Rd.			21676			U.S.A.	
	12. Was Decedent Ever in U,	S. 13. Was [		ispanic Origin? (Sp In, Mexican, Puarto	ecify Yas or No		e - Amarican Indian,
1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 XYas 2 No WW  1 Yes, Giva Year or Datas: ATT	II 10Y	as 2 No	in, Mexican, Puarto Specify:	Hican, atc.)	Specify	white, atc. White
15. Decedent's Educ	cation	16a. Decedent's	Usual Occup	ation	rin a	16b. Kind of Bu	usinass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired	during most of work f)	ung		
8		Waterma	an			Seafoo	od
17. Father's Nama (First, Middle, Last)				18. Mother's Nam	a (First, Middle	, Maiden Sumen	16)
George M. Jone	es			Elizal	beth J.	Fairbar	ık
19a. Informant's Name/Ralationship (Typ	pe, Print)	19b. Mailing Ad	dress (Street	and Number or Rui			
M. Virginia Jones	s Wife	P.O. Bo	x 13,	Wittman,	Maryla	nd 2167	6
20a. Mathod of Disposition  1	emovel from State	tace of Disposition emetery, cremetory lghman Me	y or other plac	Feb.	$7, \overset{\text{Date}}{2}, 00$		City or Town, Stata chman, Maryl
21. Signature of Funeral Service License			ne and Addras	1	- 3	1115	diniant, mary
<b>M</b>	9 1			. Leonard	d Funer	al Home	
Danies 16.	Honore	312	S. Tal	bot St.	St. Mic	haels, N	laryland 216
23a. Part1. Entar the disease, or complice shock, or heart failura. List only one	cations that caused the death a cause on each line.	n. Do not entar the	mode of dyin	g, such as cardiac	or respiratory a	arrast,	Approximata Intarval Between
	Λ	4.					Onset and Dea
Immediata Causa (Final disaasa or condition rasulting In death) a.	CARDIAC	Arrie	ST				MINUTE
rasulting in death)	CARDIAC DUO 10 (0)	r as a consequence	e of):			A REC	MINUTE
_ b	RUPTUN	Z/S A	BDOM	INAL A	HORTTC	- ANEU	1984 AOU
Sequentially list conditions,	Dua lo (or	r as a consequence	e of):				
Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or injury C.							
that initiated events rasulting in death) Last	Dua to (or	as a consequence	e of):				
d.							
Part II. Other significant conditions cont	tributing to death but not resu	lting in the underly	ring causa giv	en in Part I.	23b. Did	tobacco usa co	ntributa to the cause of o
					10	Yas 2□ No	3 Probably 4 □ Un
							Data Mara automorphis
						an autopsy omed?	24b. Wara autopsy find available prior to completion of cause
							of death?
					10	Yas 2 No	1 ☐ Yas 2 ☐ No
25. Was casa referred to medical example 25.				26. Place of Deet	th (Check only	one)	
1 LV Yas 2 □ No Ho	ospitat: 1 Inpatient 2	ER/Outpatient 3[	DOA Oth	er: 4 Nursing Ho	oma 5 Ras	idance 6 DOth	ar (Specify)
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injun Work	y at k?	28d. Describe	how injury occur	red
1 Netural 5 Pending 2 Accident invastigation	( Single Sign (	М		Yas 2 □ No			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, ferm, street, fa	actory, office		28f. Location	(Street and Numb	er or Rurel Route Numbe
	Canaling, Str. (Openly				J., 0. 10	,	
29a. Certifier 1 Certifying Physic (Check only one) 1 Medicat Examine	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death occu ion and/or invastig	urred at the tin ation, in my o	na, data and place, pinion, death occur	and dua to tha red at tha time,	causa(s) and ma data and place,	annar as stated. and dua to the cause(s)
29b. Signatury and title of pertition	7		29c. License	e number		29d. Data signe	d (Month, Day, Year)
>// XXV/	1		D48	DILL		2-3-	-00
Just C	)		148	007		X-2-	00
30. Nama and addrass of person who con					3.7		
Kevin . Stitely		Dutchman	s Lane	Easton,	Maryl	and 2160	1
31. Data filed (Month, Day, Year)	32. Registrar's Signal	rure A	,				
FEB 0 8 2000	free to the total	19. A	now No	/			

DHMH 16 Ray 6/95

Regis



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6 6 4 8 3 Certificate of Death 8. Detection of Death 8. Detection of Death 9. Dete

100	)	Physic /Med Exami	ical
		Funeral Director	_
	with the Maryland	Sa or 28a-f show at be notified at	Il Director

iif. Pages 1 and 2 should be filled within 72 hours after death with th schnent of Health and Mental Hygiens. Infant: if liem 27 is marked other than "natural", or items 23a or 21 injury or other traumatic event, the Medical Exeminer must be no

Evelyn Kemp Baltimore, Maryland 21215-0020

> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer death.

To the Funeral Director: Afer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

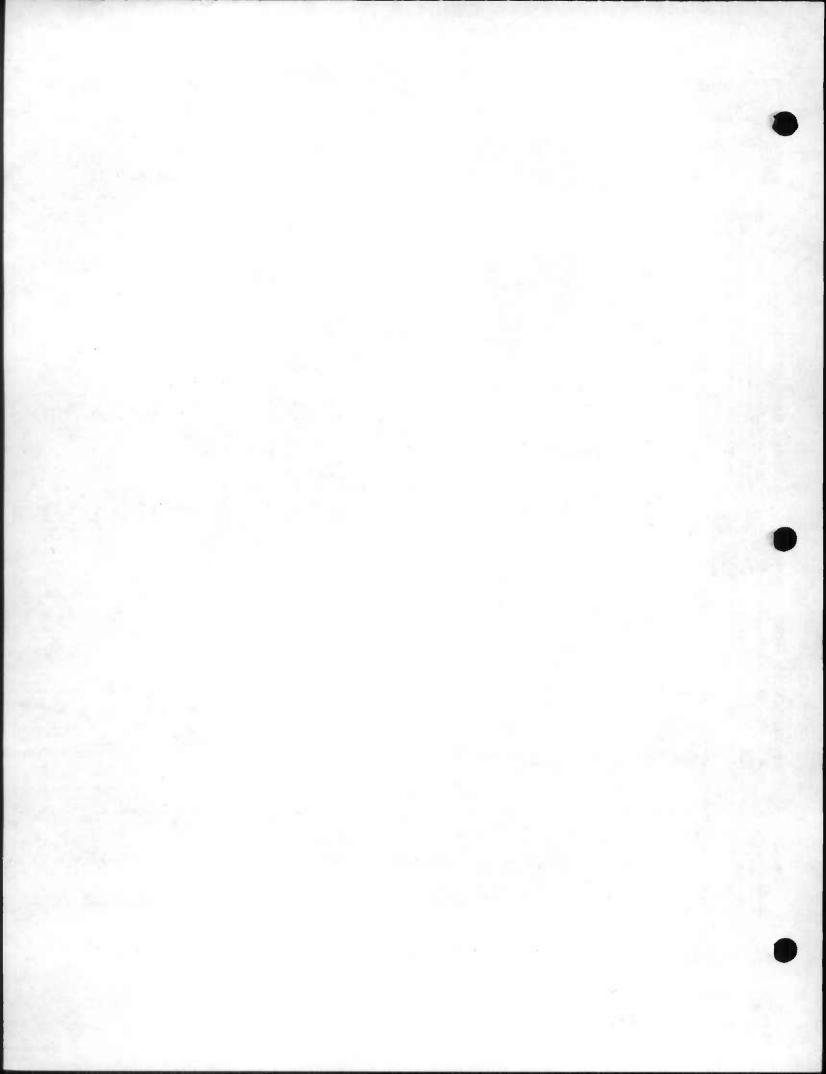
Division of Vital Records, P.O. Box 68760,

1. Decedent's Neme (First, Middle, Last	)				2. Dete of Month	Death Dey	Year	3. Time of Death
EVELYN	CARRIE K	<b>E</b> VIP					6,2000	0715
4e Fecility Neme (If not institution, give	street and number)			4b. City, To	wn, or Location of D		County of Deat	
	rial Hospit				aston			Lbot
215-18-4020	7. Age (In yrs. 83	last birthday) Yrs.	if Under 1 Y Months D	ear If Under eys Hours	Min. (Month	Birth Dey, Year) 26, 19	9. Bin Co	nplece (Stete or For untry) yland
Usuel Residence of Decedent  10a. Stele 10b. County	10c. Cit	y, Town or Loc	ation					10d. Inside City Lin
Maryland Talbot	S	t. Mich	aels					1 ☐ Yes 2
10e. Street and Number			10f. Zip Co	de		10g. Citiz	en of What Co	untry?
116 St. Michaels C	ottages		21663			U.S.	Α.	
11. Meritel Stetus 1 Never Merried 2 Married	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give	H.	es Decedent Yes, specify	Cuban, Mexicar -	igin? (Specity Yes o n, Puerto Rican, etc.	)	4. Race - Ame Bleck, White Specify: Wh	e, etc.
3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Detes:	16a Dacada	ent's Usuel O	ocupation		16h Kin	nd of Business/	nduetna
(Specify only highest grad	le completed)	(Give k	ind of work d O NOT use n	one during mos etired)	t of working	TOD. KIII	id of Edsiriess	Houstry
Elementery/Secondary (0-12)	College (1-4or 5+)	Clerk				Re	etail D	rug Store
17. Father's Neme (First, Middle, Last)				18. Mothe	er's Neme (First, Mid	ddle, Meiden S	Sumeme)	
David E.	Baynard			Ca	arrie Stra	annahar	1	
19a. informent's Neme/Reletionship (7)  David H. Kemp	rpe, Print) Son				or or Rural Route Nu ottages	imber, City or St. Mic	Town, State, 2 chaels,	Md. 2166
20e. Method of Disposition		Pleca of Dispos	ition (Name o	of place)	Dete	20c. Loc	cation - City or	Town, Stete
1 Suriei 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)					k 2-9-2000	East	ton, Ma	ryland 21
21. Signeture of Funerel Service Licens		22	Neme end A	ddress of Fecili	tv			
Derugn &	Lornar				onard Fun			1 1 0100
23a. Pert1. Enter the disease, or compleshock, or heart fellure. List only or	icetions thet caused the deet	h. Do not ente	the mode of	dving, such es	St. St. M	cnaels	s, wary	Approximete
shock, or heart fellure. List only or	ne cause on eech line.							Onset end Deeth
Immediate Cause (Final	Rectal	- AO	11/	PYN	inte			7 mo
disease or condition resulting in deeth)		or es a consequ		C	~ ( )	_	j I	
	500 (0 (0	7 00 tt 001130qu	01100 01).				1	
Sequentially list conditions, if eny, leeding to immediate	b. Due to (c	or es e consequ	enca of):					
cause. Enter Underlying							i	
Ceuse (Diseese or injury that initiated events resulting in deeth) Last	Due to (o	r es e conseque	ence of):				†	
Todaking in Good ij Edgi							1	
	J	-यं						
Pert ii. Other eignificant conditions cor	ntributing to death but not res	ulting in the und	derlying caus	e given in Pert i	i. 23b.	Did tobacco	uee contribute	to the cause of dec
						1 □ Yee 20	DN0 3□P	obably 4 Unkr
					24a. \	Was en autop: performed?	9	Were outopsy finding available prior to completion of cause
								of death?
					1	☐ Yes 2☐	No	I □ Yes 2 □ No
25. Was case referred to medical axeminer?	donaite i				of Deeth (Check o	nly one)		
TEL TES ZEPINO		ER/Outpatient	3 DOA		ursing Home 5 F			cify)
27. Menner of Death  1 Deturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c.	injury et Work? 1 ☐ Yes 2 ☐		ibe how injun	occurred .	
3 Suicide 4 Homicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specification)	ome, ferm, streety)	et, fectory, of	fice		on (Street end Town, State)		irel Route Number,
(Check only 2 Medical Exami	eician: To the best of my kno ner: On the basis of examine end menner steted.	wiedge, deeth o	occurred et the estigetion, in	ne time, dete an my opinion, dee	nd placa, end due to oth occurred at the ti	the cause(s) me, dete end	and menner as pleca, and due	stated. to the cause(s)
one)			1			004 Date		
29b. Signeture and title of certifier	Λ		29c. Li	cense number		290. Dete	signed (Mont	h, Day, Year)
one)	li wo.		29c. Li	389°	90	290. Dete	-	h, Day, Year)

DHMH 16 Rev 6/95

Registrar

FEB 0 8 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** MARY ELIZABETH February 8, 2000 King 6:45am · /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT If Under 1 Yaar 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2X F Months Days Hours Yrs. 216-46-5924 88 AUG. 4, 1911 Director MISSOURI Usual Residence of Decedent the Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at 1 □XYes 2 □ No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 end 2 should be filed within 72 hours efter death with I ent of Heelth and Mentel Hygiene. nt: If Item 27 is marked other than "naturel", or Items 23a or? 501 DUTCHMAN'S LANE 21601 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give Year or Datas: 14. Rece - American Indien. Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: WHITE p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) LOREN GEORGE LOGAN BESS L. THORPE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. KING/ SON 1487 HIIKALA PLACE, HONOLULU, HI 96816 other altimore, 20b. Pleca of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stata Injury or permit. Page Department of Important: If any Injury or CHESAPEAKE CREMATION CTR. 2-10-00 CHESTER, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUENRAL HOME, P.A. 21. Signature of Funarai Service 200 S. HARRISON ST., EASTON, MD 21601 Part1 Enter the disaasa, or complications that causad the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Interval Batween Onsat and Daath Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Years **Examiner** Due to (or es e consequence of): Examiner physician end the burial-transit that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physiclan/Medical Due to (or es a consequence of): ò Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by i 1 Yes 2 100 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to Completed 24a. Was an eutopsy performed? peen complation of cause of death? has 1□ Yes 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: 1 Yes 2 0 Other: Danie S Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Marther of Deeth 28e. Dete of injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Pending s after death. 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier edical 29b. Signature aper fittle of centily 29d. Data signed (Month, Day, Year)

29c. Licensa number

219

32. Registrar's Signature

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18/00

S. Washington St Easton Mo 21601

State Registrar 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Allow mo

FEB 10

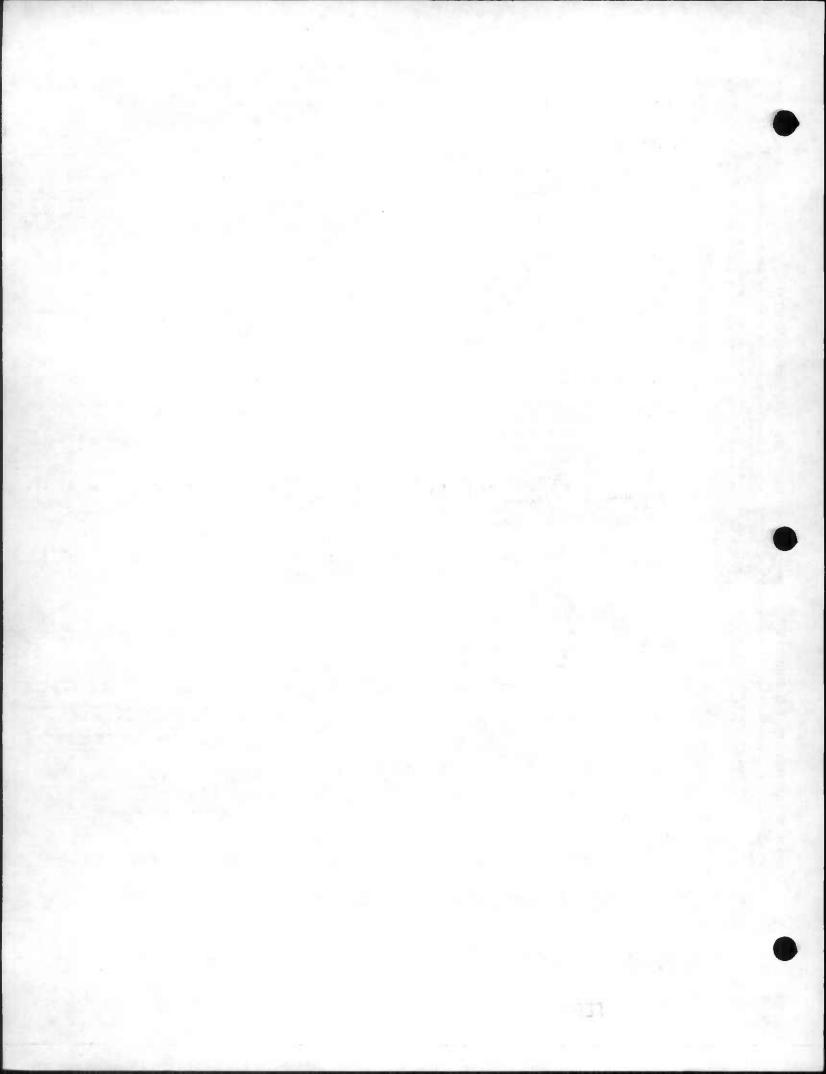
2000

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31. Date filed (Month, Day, Yeer)

			State	of Marylar		artment of rtificate or		ind Mental Hy	rgiene () (	0 0	15485	)	
	Di di	1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month	eath Day	Yaar	3. Time of Dea	ath	
	Physician /Medical	GEORGE	STANLEY		I	KLAPKA ,	SR.	FEB.		000	7:25 A	M	
	Examiner	4a Facility Name (If not institution	n, give street and n	umber)			4b. City, Tov	wn, or Location of Dea	ath 4c. County of Death				
		24308 MARLYN I 5. Social Security Number	RIVE 6. Sex	7. Aga (In yrs.	last hirthday	If Under 1 Yas	HARN or If Under 2			LINE	lana /State or Fo	ion	
Н	Funeral Director	218-18-6431	1⊠M 2□F	7.5	Yrs.	Montha Day		Min. 8. Data of Bi (Month, D		lace (Stata or Fo stry) YLAND	raign		
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	show det	10a. Stata 10b. County	DOI THE	10c. Ci	ty, Town or Lo					0d. Insida City Li			
	vith the Me or 28s-1 s be notified Director		ROLINE			PRESTON		1 ☐ Yes 2X No					
	death with the Meryland ms 23s or 28s-f show trust be notified at	10e. Street and Number	D.7117			10f. Zip Coda		19 / 18	10g. Citizen of What Country?				
	urs after death with or thems 23s	24308 MARLYN DI		cedent Evar in U	J.S. 13.	Was Decedent of	655 Hispanic Orig	nin? (Specify Yea or N	USA 0- 14. Rac	e - Amaric	an Indian,		
0		1 Nevar Married 2 Marr	Armed I	Forcas?		If Yas, specify Cu	ıban, Maxicen,	Puarto Rican, atc.)	Blad	ck, Whita,			
00	72 hours after natural; or te	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Yaar or	Datas: 1943	-1946	1□ Yas ¾QN	o Specify:		Specify	· WH	LTE		
21215-0020	ied within 72 ho tygiene. her than "naturn 14, the Westerl Completed	15. Decedent (Specify only highest	t's Educetion st grada complatac	1)	(Giva	dent's Usual Occ kind of work don	a during most	of working	16b. Kind of B	usinass/Ind	dustry		
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Maryland	12. Fia	19a. Informant's Name/Ralations NANCY J. KLAP		HIE				r or Rural Routa Numi			Code)		
	s 1 end Heelth tem 27 other tu	20a. Mathod of Disposition		20b. I	Place of Dispo	osition (Nama of							
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Baiti	permit. Peges 1 end Department of Heelt Important: if New 21 any Injury or other 1 once.	21. Signal to Funeral Service Licenses  22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 2160											
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no	After fune	1 Natural 5 Pandin 2 Accident invastig	g (Mc	onth, Day Year)	Injury	W	ork? □Yas 2□t						
Division of Vital	or Attending Physicien: The is site destr.  Jin by the funeral director, pege triffication: To Be Com	3 Suicida 6 Could i	not be 28a. Plac	e of Injury - At h	ome, farm, st	reet, factory, offic	×8		(Street and Numl	ber or Rure	al Routa Number,		
á	s effer il Directif Certif	4 Homicida	buil	ding, etc. (Speci	ועי)			City of 16	own, Stata)				
	To the Hospital or Attending P within 24 hours alter deeth rother Funeral Director. After to ompletely filled in by the funeral Medical Certification:		Examiner: On the					d place, and dua to the h occurred at tha time					
	within vithin comp	29b. Signature and title of certifier	10	h:		29c. Lice	nse number	1	29d. Data signe	d (Month,	Day, Year)		
		1 km/1	11/10	- W		03	5974		2/9/	00			
		30. Name and addrass of person		use of death (Ite	m 23a) (Type,	Print)		11.21	, ,				
		3 0 0	nems C	one	Eas	tore my	) 2	1601					
	State Registrar	31. Data filed (Month, Day, Year)	1 0 2000	Registrar's Sign	atura	B. 1	Dai Ha	,					

Registrar



# Rosalie Lipscomb aryland 21215-0020

				State of M	Marylan		rtment of	Health and I		giene	0	06486	
		Decedent's Neme (First, Middle, Last)						2. Date of Death 3. Time of Death					
	Physician /Medical Examiner	ROSALIE RICHTER LIPSCOMB						February 4, 2000 1147 A.M.					
		4e Facility Name (If not institution, give street and number)						4b. City, Town, or	or Location of Death 4c. County of Death				
		The Memorial Hospital						Easton Talbot					
	uneral irector	5. Social Security N 217-14-75	ar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 11/13/1911 9. Birthplece (State or Foreign Country) MARYLAND										
Pug	ent of Health and Mentel tryging it if item 27 is merked other by or other traumetic avant.  To Be Co	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location 10d. In										0d. Inside City Limits	
Maryle		MD TALBOT				EASTON						1 ☐ Yes 2 No	
th with the		10e. Street and Number 7786 OCEAN GATEWAY						e 21601 10g. Citizen of Whet C				itry?	
020 urs after dea		11. Meritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Wes Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Year or Detes:				,S. 13. Wes Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici			pecify Yes or No- o Rican, etc.)	or No- 14. Rece - American Indian, Bleck, White, atc.  Specify: WHITE			
2-0 2-2		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during me							t of working			Business/Industry	
127 William		Elementary/Secondary (0-12) College (1-4or 5+)			r 5+)	(Give kind of work done during most of world life. DO NOT use retired)  OPERATOR			TELEPHONE COM			MDANV	
		17. Father's Name (First, Middle, Last)						18. Mothar's Nama (First, Middle, Maiden Surname)					
/lan		ADAM RICHTER					HELEN MA			RY SAUERWALD			
2 she		19a. Informant's Name/Relationship (Type, Print) BARBARA McDONALD/DAUGHTER				19b. Mailing Addrass (Street and Number or Rural Rout 10807 MOONLIT MEADOWS COU							
Fe,		20a. Method of Disposition  20b. Plece of Disposition (Neme of cemelery, cremetory or other plece)  20c. Location - City or Town, Stete											
Peges nent of		1 \text{\te}\text{											
Demit. Peges 1 a Department of Hea	Important: any Injury DDCB.	21. Signature Funeral Service Licensee  22. Name end Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON MARYLAND 21601											
	ding physician and sees the buriel-transit aminer											Approximete Interval Between Onset end Deeth	
/ /M		Immediate Cause (Final disease or condition						1156				20 14/84	
Exa		rasulting in death)  Due to (or as a consequence of):								~ more			
P		H=//FI		b. Poolso	Podrable Pulmoncoy Embo						1	20 Min	
ata be execut		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
ata be ex		Cause (Disease or injury that initiated events											
		resulting in death) I	Last	d	000 10 (01	00 0 001304			I fel		1 1		
death cert	od for	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa							23b. Did tobacco use contribute to the cause of death?				
that the	To the Function of the control of th	paralysis of bilateral lower extremities					0	1				Probably 4 Unknown	
Mecords,							tee		24a. Wes en autopsy performed?		av	ere autopsy findings ailable prior to mpletion of cause	
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I or Attanding after death.	al Director: After to ed in by the funeral Certification:									nas as Oues	I Charte March or		
a far	d in by	determined    See Place of Injury - At home, ferm, street, fectory, building, atc. (Specify)						9	281. Location (Street end Number or Rural Route Number, City or Town, State)				
the Hospital	pletely fille	29a. Cartifier (Check only one)  Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.  Check only one)											
To the within	To the	29b. Signature agg	the of footilier	1-1	1	D	0	nse number		29d. Date signe	d (Month,	Day, Year)	
		30 Name and address	Dew	relled	doub (to		) DO	05457	6	02/8	14/	00_	

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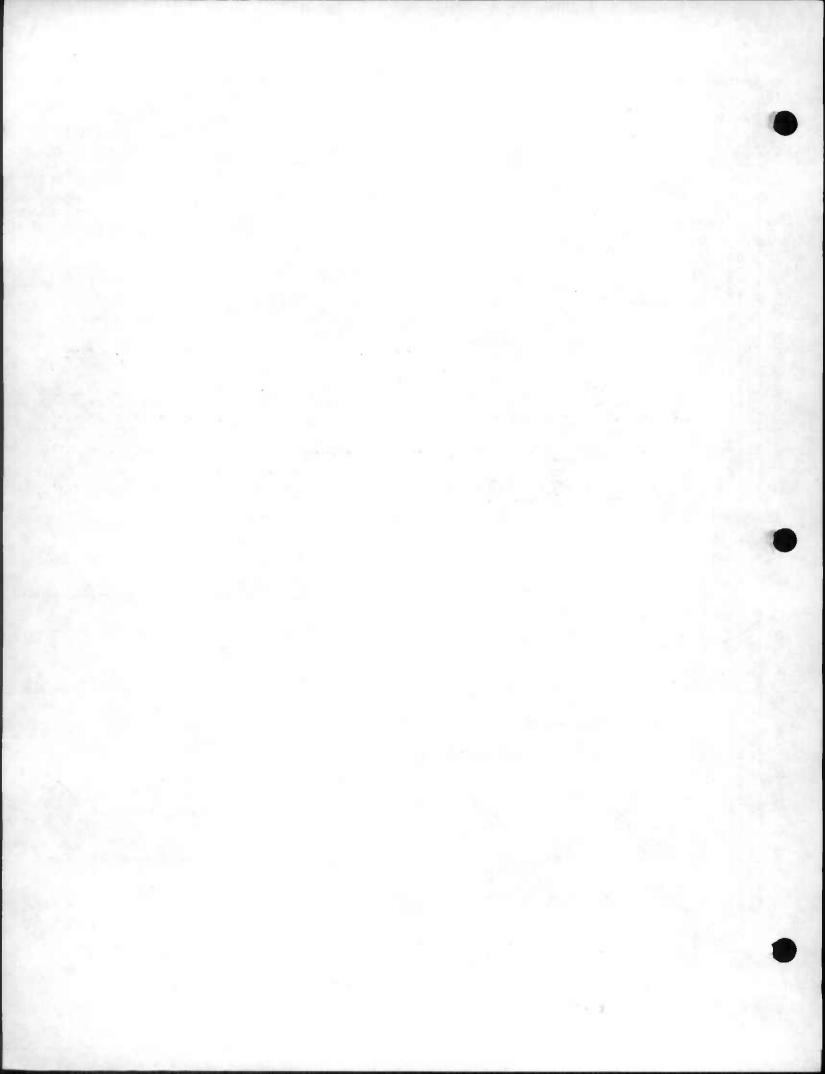
DHMH 16 Rev 6/95

State Registrar RACHEL BURDICK, M.D.

31. Dete filed (Month, Day, Year)
FEB 0 7 2000

32. Registrar's Signeture

219 SOUTH WASHINGTON STREET, EASTON, MD 21601

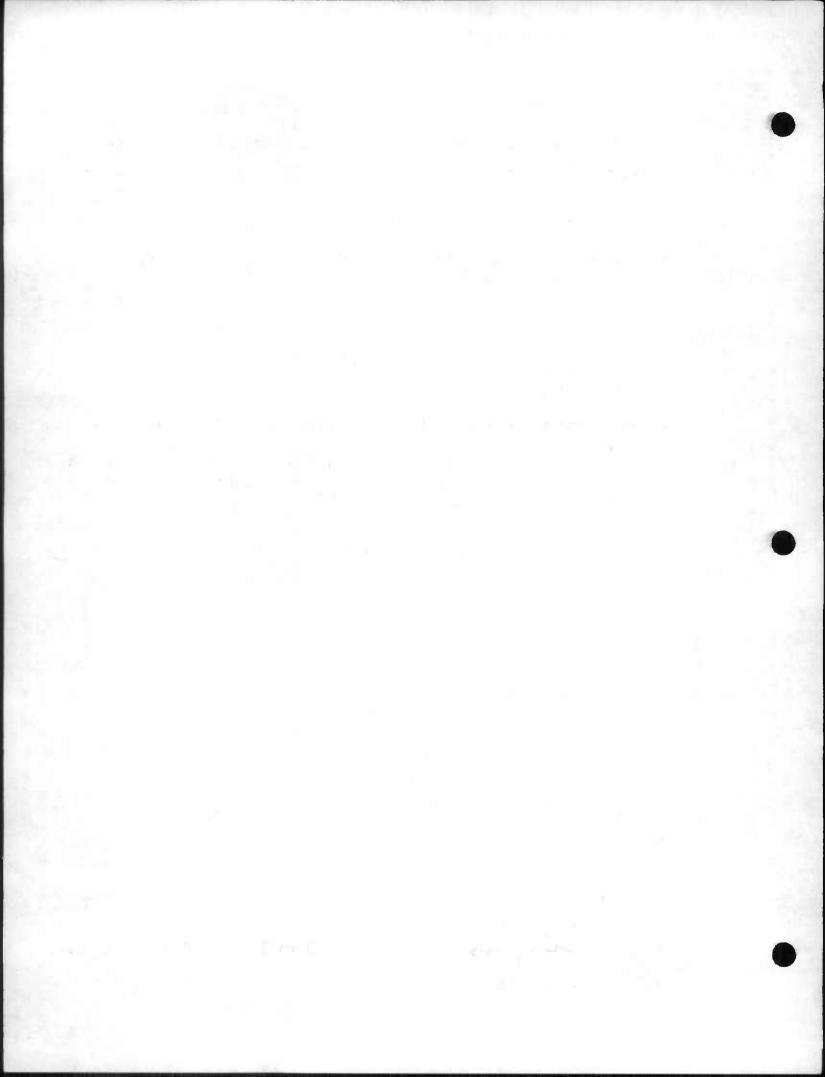


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			7-17
State of Maryland	Department of Health and	Mental Hygiene	JU

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** Millicent B. Morton 1, 2000 February 9:55 PM /Medical 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 719 Maiden Choice Lane #HR244 Catonsville Baltimore | If Under 1 Yeer | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Nov. 25, 1 5. Sociei Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign Country) New York **Funeral** 1 □ M 2XX 137-16-6702 80 Yrs. 1919 New Director Usual Rasidence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinating the nutrited at tXXYes 2 No MD Baltimore Catonsville Direct 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 719 Maiden Choice Lane #HR244 21228 USA Funeral 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yas 2 No If Yas, Giva Yeer or Datas: 1 ☐ Navar Merried XX Merried Baltimore, Maryland 21215-0020 1 Yas 2000 Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 7 Hygiene. and Mentel Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Fethar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be filt.
Department of Heelth and Mentel try, important: If Nem Z7 is marked oth any july or other traumatic eventable. 18. Mothar's Nama (First, Middla, Maldan Sumama) Be William J. Britton 10 Grace Williams 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charles L. Morton/Husband 719 Maiden Choice Lane # HR244, Catonsville, MD,21228 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Data 1 ☐ Burial XX Cramation 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Othar (Specify) 2/3/00 Catonsville, Maryland 22. Name and Addrass of Facility Donaldson Funeral Home, P.A. 21. Signetura of Funarai Service Licenses 313 Talbott Avenue, Laurel, Maryland, 20707 ance 23a. Part1. Entar ha disaase, or complications that caused the daeth. Do not anter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Intervel Between Onset and Death **Physician** /Medical immediata Carsa (Final diseesa or condition rasulting in daath) Bladder Cancer munths **Examiner** Dua to (or as a consequance of) Examiner physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Cause (Disaasa or injury Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated avants resulting in death) Last Dua to (or as a consequence of): 83 attending 980 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eun detached 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has page 2 1 ☐ Yes 2 No certificate 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminar? director Be 26. Placa of Death (Check only one) Hospital: 1 inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 ☐ Yes 2 No P this funeral 27. Manner of Deeth 28a. Data of injury (Month, Day Year) 28b. Tima of injury 28d. Describe how injury occurred Certification: 28c. injury at Work? After t 11 Netural 5 Panding Investigation death. 1 Yes 2 No Director: / 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after hin 24 hours af the Funeral Di npletely filled in Hospital Certifying Physician: To tha best of my knowledga, daath occurred at the tima, dete end placa, and dua to tha causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and dua to the causa(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2.
To the F 29b. Signature end title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) D4744 February MID 2 2000 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) Andrew Catonsville Mary land. LAZITS 711 Mailen Choice Lane 31. Data filed (Month, Day, Year) FEB 0 3 2000 32. Dégistrar's Signatura State Registra



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month Year ENA **Physician** MORANIEC CREASY ~ YAM 2000 - /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9554 Westwood Court Ellicott City Howard If Under 1 Yaar | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Deys 226-28-5459 May 25, 1926 Virginia 73 Director Usuel Residence of Decedent the Maryland 10a Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flams 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 X No Directo Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 9554 Westwood Court 21042 United States Pages 1 and 2 should be filed within 72 hours after deeth neat of Health and Mental Hygiene. wit: If lean 27 is marked other than "naturel", or items 23. my or other fraumatic event, in Weden Eas, in the manner. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2% No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Maritel Status Bleck, White, etc. 1 Nevar Married 2 Married 1 Yes 2€ No Specify: Specify: þ 3 DWidowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Social Security Elementary/Secondery (0-12) Collega (1-4or 5+) Claims Examiner Administration 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Thomas Creasy Elsie unknown 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Pamela E. Fisher/Daughter 1696 Lilac Circle Willits, CA 95490 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or Baltimore National Cem. 2-10-2000 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funarel Service Licensee m01044 4112 Old Columbia Pike Ellicott City, MD 21043 Dem a Cole With 23a. Pert1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Atheroscleratic Cardiovasalan Disease /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician end the burial-transit the deeth certificate be executed Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) ottending pt signed by the e 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 □ Yes 2 □ No 3 □ Probably Unknown þ 24b. Were autopsy findings aveilable prior to should s Completed 24e. Was an autopsy completion of cause of death? certificate has b 1 Yes 200 1 ☐ Yes 2 No director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) exeminer? 12 ¥es 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 funeral Certification: 28e. Date of Injury (Month, Day Year) 28c. fnjury et Work? 28d. Dascribe how injury occurred 27. Magner of Deeth 28b. Time of 1 Naturel 5 Pending Invastigation Injury 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, State) 5 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated edical 2 Madical Examinar: On the basis of examination end/or Investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) end menner stated.

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifice To the Hospital or within 24 hours eff To the Funeral Di completely filled in

Baltimore, Maryland 21215-0020

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State Registrar

PATRYCE A 31. Date filed (Month, Day, Year) FEB

1 0 2000

29b. Signeture end title of cartifier

at

4565 TOY ٤ inn 32. Registrer's Signature

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Hemlock Cone Way Elliott

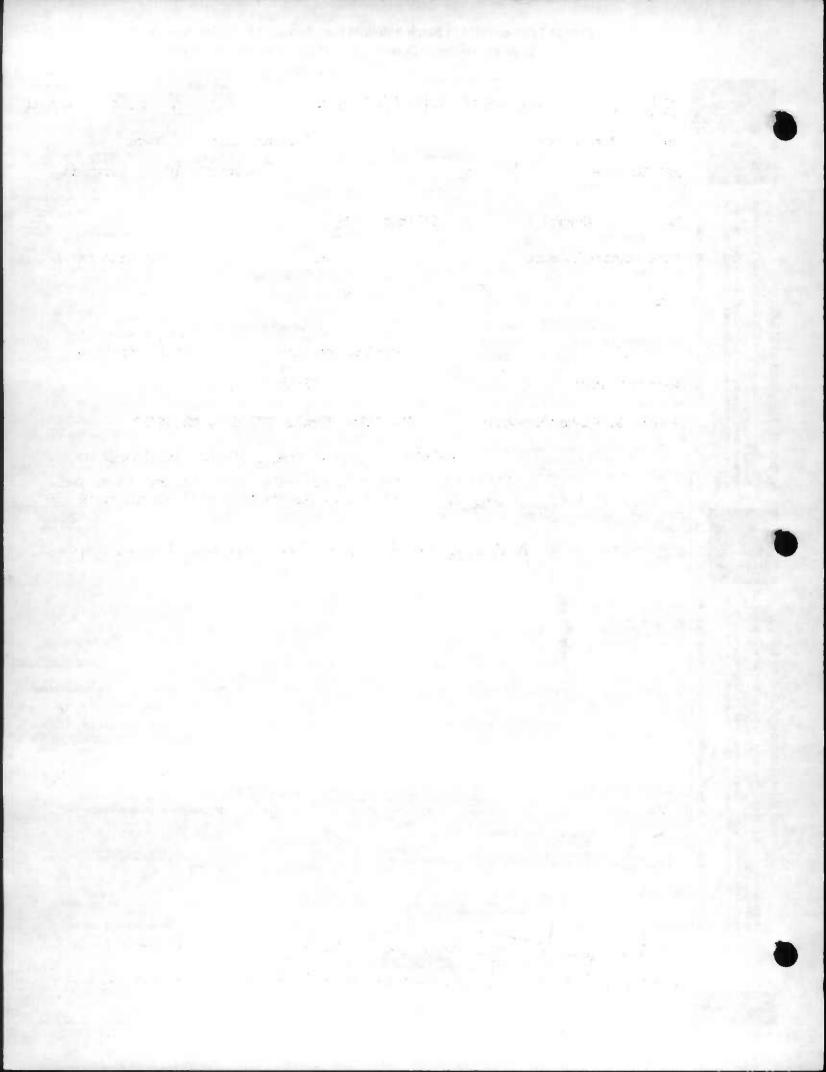
29c. License number

1 Synot

29d. Dete signed (Month, Dav. Year)

2000

21012



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Physician **JAMES** ANNA MEADE Feb /Medical 4 2000 11:00 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner The Pines Easton Talbot Genesis ElderCare -If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 10/11/1913 Birthplace (State or Foreign Country)
 MARYLAND 5. Sociel Security Numb 212-12-2006 **Funeral** 10 M 20 F Months Deys Hours 86 Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai", or items 23s or 28s-f shore Examiner must be notified at MD TALBOT EASTON 1 Ves 2 □ No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMAN'S LANE 21601 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (∑No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 Ie merked other than "natural", or Nei eny Injury or other traumatic event, the Medical Examples. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE py 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) **JOSEPH JAMES** ELSIE MERRICK 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT J. MEADE/SON 29309 PIN OAK WAY, EASTON, MD 21601 20e. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State LOUDEN PARK CEMETERY 1 N Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 2/8/2000 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON MARYLAND 21601 21. Signiture of Funeral Service Licenses 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical DNEWMONIA Examiner Due to (or es a consequence of): Physician/Medical Examiner Incha The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of). Box 68760. manition Due to (or es a consequence of): helmans 180 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 TNO 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Neturel 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifie MD 30 Name and address of parson who completed cause of death (Item 23a) (Type, Print) 508 LI) WEWILD 31. Date filed (Month, Day, Year)

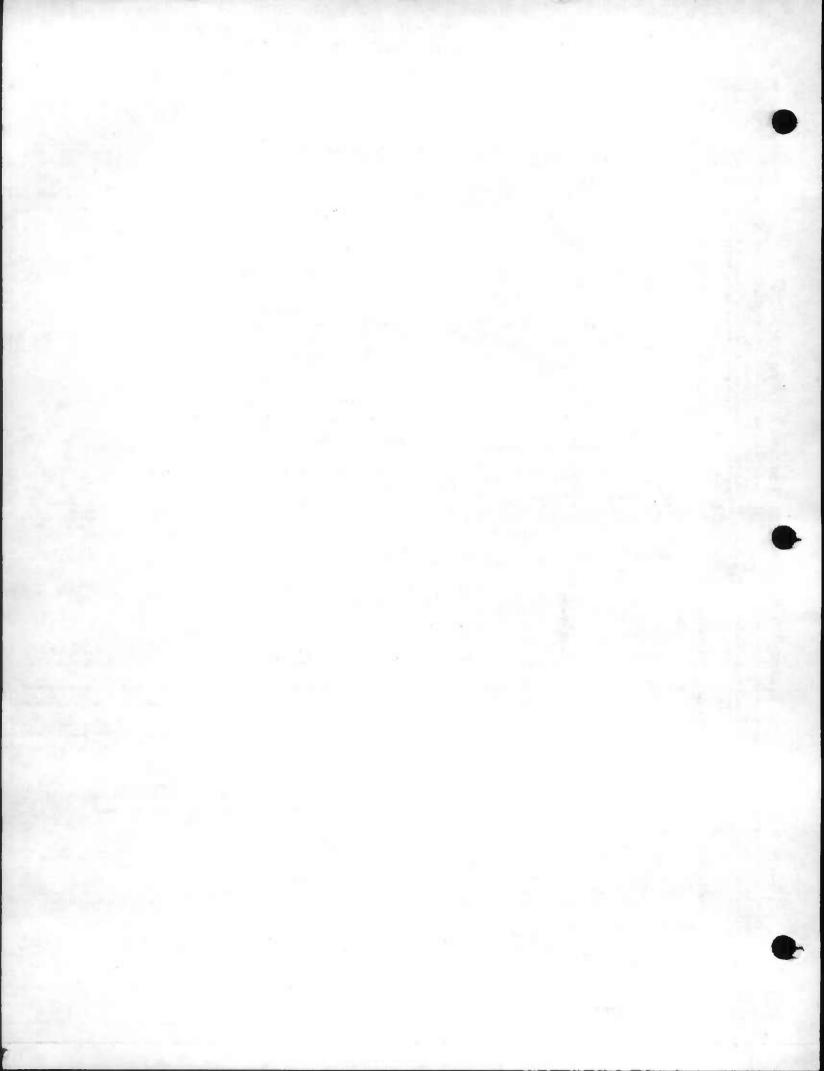
**DHMH 16 Rav 6/95** 

State

Registrar

32. Registrer's Signeture

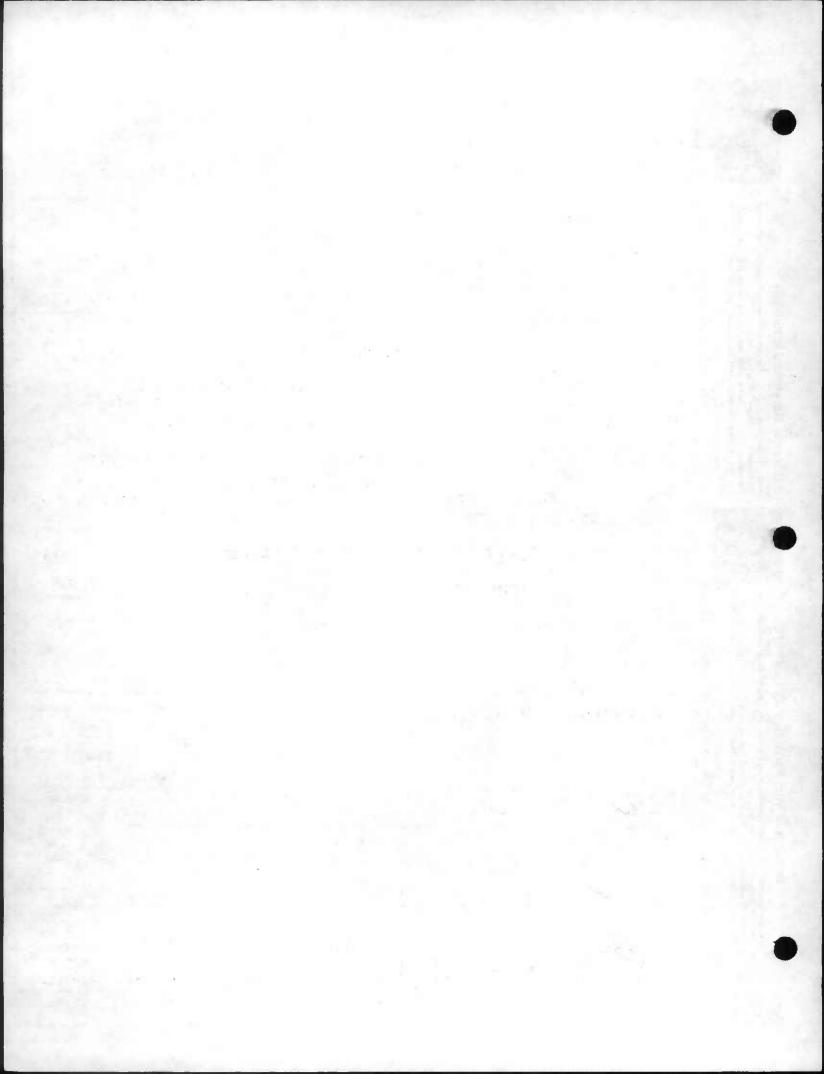
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	11. Marital Stetus			12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic			spanic Origin? (5	c Origin? (Specify Yes or No- oxican, Puerto Rican, etc.)		Race - American Indian, Black, White, etc.		
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Day Month Year L. 2000 02 06 7:25 P.M. Emma Stafford /Medical 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Bay Nursing Center Cambridge Dorchester Mallard If Under 1 Year 8. Dete of Birth (Month, Day, Year) April 2, 1908 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 2□ F 91 Yrs. Florida Director 216-16-7071 Usual Residence of Decedent with the Maryland 10a Stete 10b County 10c. City, Town or Location 10d Inside City Limits r than "natural", or itema 23a or 28a-f show the Mexical Examiner must be notified at Director Maryland Dorchester 1 X Yes 2 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Ave. 21613 U.S.A. Funeral deeth 11 Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 127 is marked other than "n traumatic event Pages 1 and 2 should be filed within nent of Health end Mentel Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Line Worker 8th grade Phillip Packing Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Daniel Bryant Hattie Bryant 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health er Important: If Hem 27 Is any Injury or other trau Evelyn Bryant, Daughter 716 Rosemont Ave., Cambridge, MD 21613 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete Mt. Tabor Cemetery 2-12-00 Marianna, FL 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sergice Licensee 22. Name end Address of Facility Bennie Smith Funeral Home Post Office Box 1687 Easton, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final · Cerebro Vascular Accident disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Physician/Medical Examiner Hypertension Yeun The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): 9.5 P.O. 1 been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings sveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attanding Physicien: 24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? B 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Tursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2€ No funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29e. Certifier completaly To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2/7/2000 DNT41. webte 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) St. Cambridge MD 21613 Mehta Byin Vinodrai MD 402

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dey, Year)

FEB 0 8 2000

32. Registrer's Signeture

## Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 28, 2000 10:01 PM Month **Physician** Woods Donald January /Medical 4b. City, Town, or Location of Death 4c. County of Dooth Prince George's 4a Facility Neme (If not institution, giva street and number) **Examiner** Hospital Regional \_aure 8. Date of Birth (Month, Day, Year) July 26, 1937 If Undar 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Min. ùCXM 2□ F 62 Months Hours Yrs. 183-30-6572 Pennsylvania Director Usuai Residence of Decedent the Manylend 10c. City, Town or Location 10d. Inside City Limits 10e. Stata 10b. County rthan "natural", or itsms 23s or 28s-f show the Medical Examiner must be notified at 1KXes 2□ No Laurel Prince George Director 10f. Zip Code 10g, Citizen of Whet Country? 10e. Street end Number 20707 IISA 409 Montrose Avenue Funeral death 12. Was Decedent Ever In U.S. 14. Raca - Amarican Indian, Bieck, White, etc. 11 Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes MN No
If Yes, Give
Year or Detes: 72 hours after 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Hygiene. Construction Plumber 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Pages 1 and 2 should be nent of Health and Mentel Mildred Edmonston Paul Woods 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1104 Beall Place, Laurel, Maryland, 20707 itsm 27 l Paul Woods/Son altimore, I 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2XX remation 3 ☐ Removel from State = 5 Department of Important: If any injury or Catonsville, Maryland 2/3/00 Metro Crematory, Inc. 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name end Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland, 20707 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Daeth **Physician** CONGESTIVE HEART DAIWNE /Medical immediete Ceuse (Finai diseese or condition resulting in deeth) Examiner Due to (or es e consequence of):

ACCOR C STENDICS Examiner physicien end s the burial-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immadiete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Last PROSHOCIC CARAMEDIATA P.O. Box 68760. Physician/Medical Due to (or es e consequence of ESPILLATION signed by the e Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown MAL REGURGIFATION Records, by 24b. Were eutopsy findings evailable prior to completion of cause of death? ERUSKEMA 24a. Was en eutopsy Completed certificate has t RENAC MUNGGCIENCY 2 NO 1 Yes 1 □ Yas 2 □ No Division of Vital l or Attending Physician: after death.
Director: After this certifice 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Neturel 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 ☐ Homlcide n 24 hour. the Funeral Direction 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier edical To the I within 2 To the I complet 29b. Soneture end title of curt has 29d. Data signad (Month, Day, Year) 29c. Licensa number 36822 GROSISER/ 30. Name and autress of person who completed cause of death (Item 23e) (Type, Print)

ANULO COSENCE ZYCOMUNICADE D. 4307; SANUA N

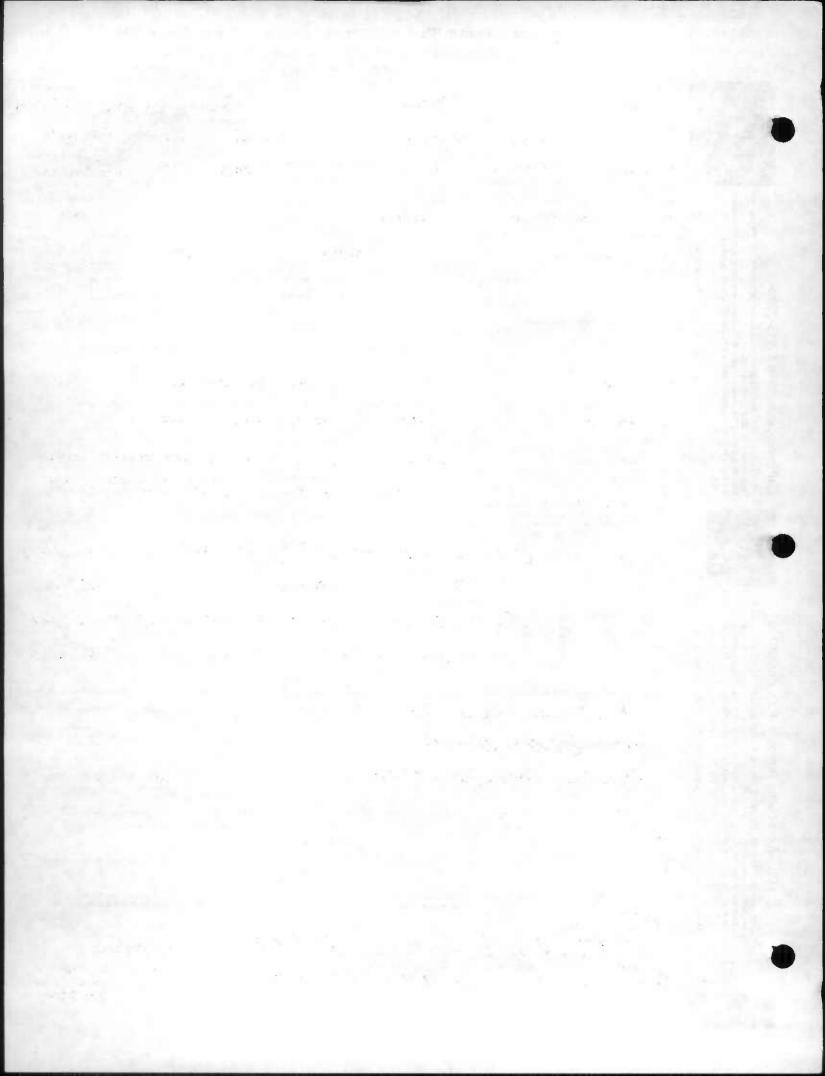
21. Date filed (Month Day Year)

32. Redistrar's Signature

20. 757 31. Dete filed (Month, Dey, Year) FEB 0 1 2000 32. Registrer's Signeture State

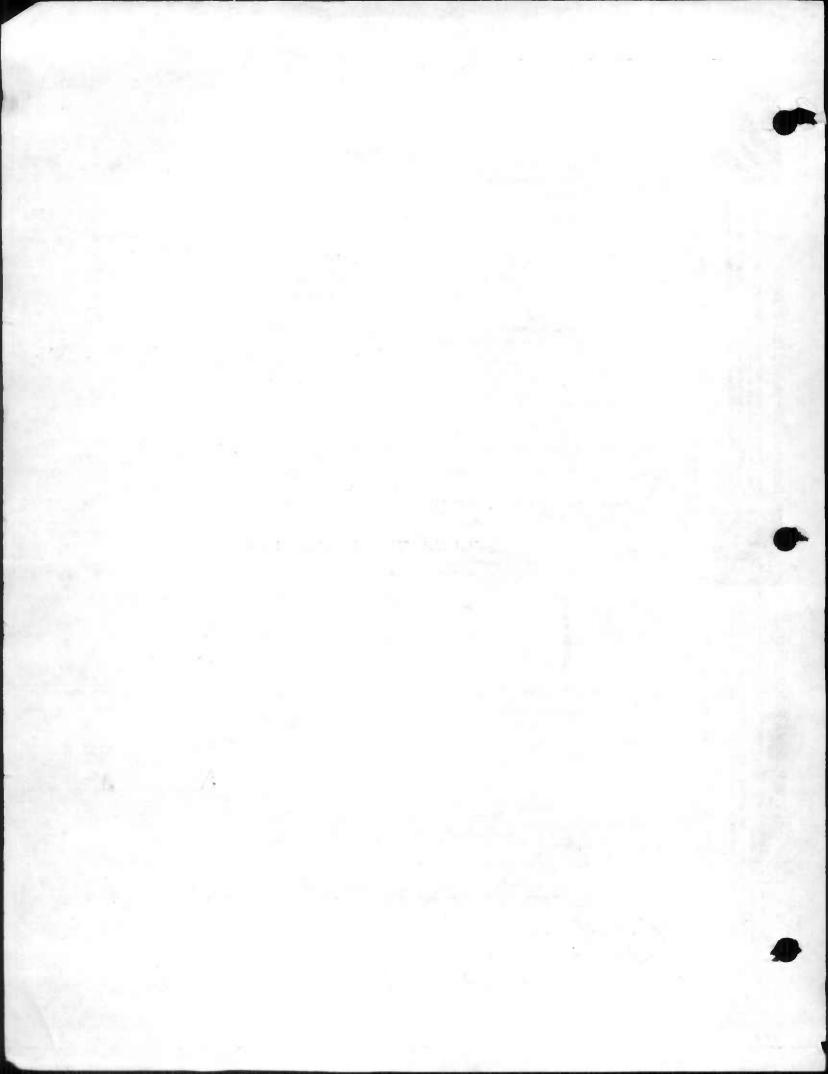
**DHMH 16 Rev 6/95** 

Registrar



State Registrar

Denna



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene O O

Amend	ed Item#10a,b,c,e,f,19b perInfg781 3/16/2000 EWCertificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. No.	0 00474						
Physici /Media	KATHLEEN W. ARMITAGE	February 8,	2000 3. Tima of Death 5:14 PM						
Examin	4e Facility Neme (If not institution, give street end number) 4b. City, Town, of Suburban Hospital 4e Facility Neme (If not institution, give street end number) 4b. City, Town, of Suburban Hospital		nty of Death Montgomery						
Funeral Director	5. Social Security Number 226-42-2996 6. Sex 1 Months Days Hours Mit Months Days Mit Months Days Hours Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months Days Mit Months	s. 8. Dete of Birth							
ith the Maryland or 28s-1 show be notified at	Usuel Residence of Decedent  10a. Stete 10b. County Montgomery 10c. City, Town or Location  PA MD Mifflin Potomac	b. County Montgomery 10c. City, Town or Location							
23e or 28	Description   Potomac								
d 21215-0020 filed within 72 hours after death with the Maryland typiene. ther than "naturel", or Heme 23a or 28e-1 show wit, the Medical Exemples must be motified.	3 Widowed 4 □ Divorced Year or Dates:	(Specify Yes or No- into Rican, etc.)  14. F	lace - American Indian, clack, White, etc.						
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hyglene. The marked other than "naturel", or the unarked other than "naturel", or the unarked other than a featurel.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	rorking	Business/Industry  ical						
laryland 212 2 should be filed with and Mental Hygiene. Is marked other than surmatic event, the	17. Father's Name (First, Middle, Last)  Bruce M. Warner  18. Mother's N  Jess	ame (First, Middle, Meiden Sum	eme)						
	19a. Informent's Name/Relationship (Type, Print)  Ann Frees (Daughter)  19b. Mailing Address (Street end Number or Informent's Name/Relationship (Type, Print)  7093  Overlook Drive		vn, State, Zip Code) 20814						
Baltimore, semil. Pages 1 ar Department of Hea Mportant: if item mortant: if item and injury or other mice.	20a. Method of Disposition  1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other place)  Metropolitan Crematory	n - City or Town, Stete xandria, VA							
Baltimo pemil. Pages Department of Important: If it eny injury or	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Funeral Service, Inc.  5517 Vine Street Alexandria, VA 22310								
Physician '/Medical Examiner	23a. Perti. Entent the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardinated cause (Final disease or condition resulting in death)  RESPIRATORY FAILURI  Due to (or as a consequence of):  PLEURAL EFFUSIONS		Approximate Intervel Between Onset and Death						
Box 68760, with certificate be exercised the certificate and for use as the buttel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
P.O.	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  AS PIRATION ON RECURRENT BASIS,  MALNUTRITION	23b. Did tobecco use contribute to the cause of deeting 1   Yes 2   No 3   Probably 4 Unknown							
Records, e law requires that been signed ge 2 should be up	MALNUTRITION	24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
Attal Re Lan. The Land ontificate ha		1 ☐ Yes 2 No	1 Yes 2 No						
4 5 0 E	examiner?	eeth (Check only one)  Home 5 Residence 6 C	Other (Specify)						
Division of the or attending Physics after death.  It blicector: After this aid in by the funeral of the funeral or certification: To		28d. Describe how injury occurred							
Divi		City or Town, Stete)	mber or Rurel Route Number,						
The Hosp Ithin 34 ho STS Funs emplestely i	29a. Certifier (Check only ane)  29b. Signeture end title of certifier 2  29b. Signeture end title of certifier 2  29c. License number	curred at the time, dete and place	manner as stated. a, and due to the ceuse(s)  ned (Month, Dey, Year)						
	1 = Ty Mysmmo 026571	2/6	100						
Sta	30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  RV I N F M Z US M D 4930 DEL RAY AVE,  31. Date filed (Month, Dey, Year)  32. Registrar's Signeture	BETHES DA,	MD 20814						
Registra	The second of the second								

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Yaeı **Physician** 8:15 PM Geraldine 25 2000 Fehruary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | 4c. County of Death Examiner Rush 11913 Wolls Columbia Columbia, MD st birthday) If Under 1 Ye Howard rass 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 165-50-6361 10 M 20 0 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Columbia MD XX Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be n 11913 Yellow Rush Passage 21044 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: t Never Married 2 Married 1 Yes 2 No Specify: White Aq Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Homemaker Own Hame 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 William. F. McCarthy Mary Adamson 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Abbott 468 Hamil Road, Verona PA 15147 20b. Place of Disposition (Name of cemetery, cremetory or other place) Calvary Cemetery February 29, 2000 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 Department of Important: If any injury or Pittsburgh, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21. Signature of Euneral Service Licensee Victor P. Doda, Jr. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused ill shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Daath Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 E Naturat 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street end Number or Rural Routa Number, City or Town, Stete)

Attending Physician: The law requires that the death certificate be assected burial-transit Bud Box 68760. physician the for use as id be detached f Division of Vital Records, P.O. cate has t this certificate funeral director.

with the Maryland

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or Reme

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. Int: if them 27 is marked other than "natural", or its

Hygiene.

21215-0020

altimore, Maryland

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

29a. Certifier (Check only one)

Medical

29b. Signatoffe and title of certifier

4 Homicide

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

anone

00052165

February

30. Name and address of person ase of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 2 8 2000

Columbia 32. Registrar's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06496 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle Last) **Physician** February 23, 2000 1025 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, give street and number, Examiner If Undar 24 Hrs. 6 Sax 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) 100 M 20 F Days Months Hours 000 AB - 870 BUSUAL Residence of Dacedant Virginia Director 10a. Stata 10b. County City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director traumetic event, the Medical Examiner must be notifi-10e. Street and Numbe 10g. Citizan of What Country? Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 MYas 2 No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Marital Status 14. Race - Amarican Indian Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion
(Giva kind of work dona during most of working
lifa., DO NOT use ratined) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry d other than Elamantary/Secondary (0-12) Collega (1-4or 5+) 18. Mothar's Nama (First, Middla, Melden Sumama) 17, Fathar's Nema (First, Middla, Last) of her mental is Informant's Name/Relationship (Type, Print)

NICLEY BRONCH 20a. Mathed of Disposition 1 DeBurial 2 Cremation 3 Ramoval from Stata Other (Specify) 21. Signature of Fundral Service License for complications that caused the death. Do not anta-list only one ceuse on each line. Approximata Interval Batween Onsat and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical potension Luamine Dua to (or as a consaquanca ot) Examiner physiclen end the buriel-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarfying Cause (Diseasa or Injury that initiated avants rasulting in daeth) Last Due to (or as a consequence ot): Physician/Medical Dua to (or as a consequence of): 98 esn for Part II. Other algnificant conditions contributing to death but not resulting in the underlying couse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy tindings svailabla prior to complation of causa of daath? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No director, 25. Wes cesa retarrad to medical axaminar? Be 26. Placa of Daeth (Check only ona) 1 Yas 2 No Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) P 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation t Matural efter death. 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian 29d. Data signed (Month, Day, Year) 00 Dalsames

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Pages 1 and 2 Item 27

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Division of Vital Records, P.O.

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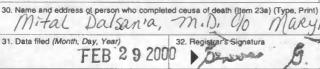
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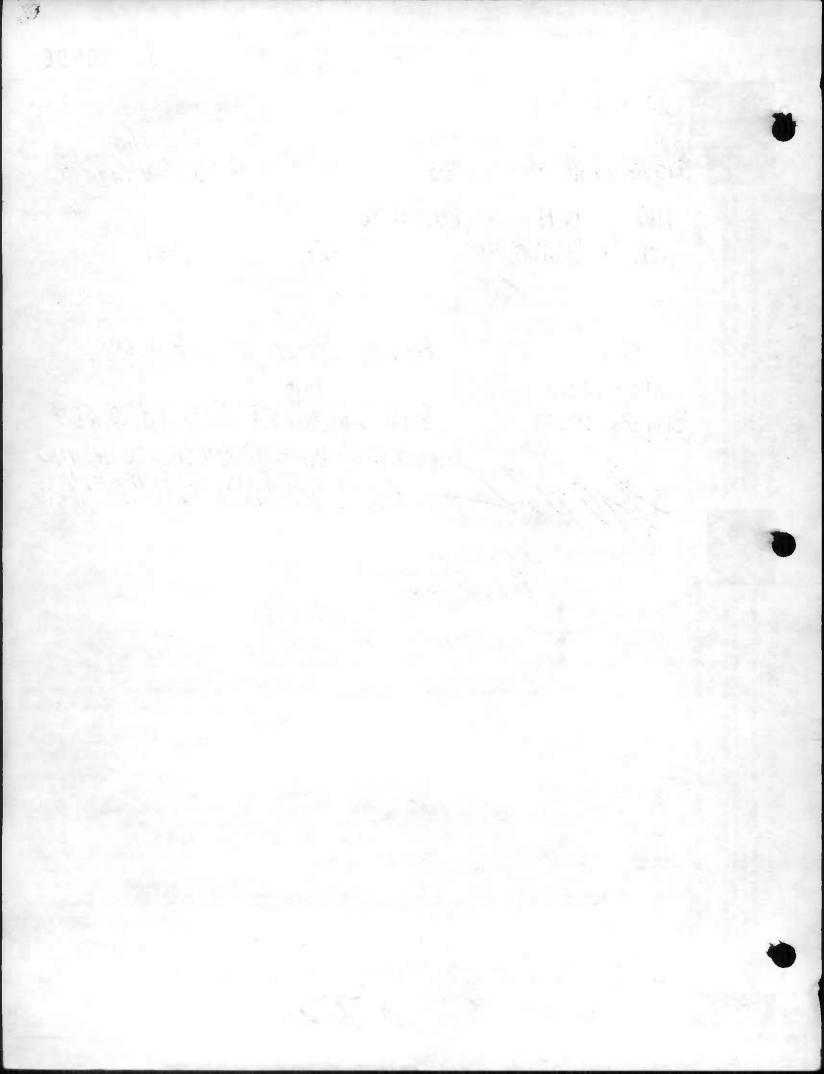
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31. Data filed (Month, Day, Year) FEB 2 9 2000



Maryland

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Arnold 18 2000 Tabatha Lynn February 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Arundel Medical Center Arundel 4nnapolis Anne Anne If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 10 M 20 F Months Days NA Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No (slen Hone. Durnie 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 21061 SW 3rd USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) IVA AW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) lanie Edward rnolo ar 19b. Meiling Address (Street and Number or Nural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel E. Amold Parent 3rd Glen Burnie, Md 5.W 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Dete 20c. Location - City or Town, State 1⊠Burial 2 ☐ Cremation 3 ☐ Removel from Stete Voshell Mem. Gardens Feb 25, 2000 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Dack, X. Charles L. Stevens twere I Home Inc. 22. Name and Address of Facilit 1501 E. Fort Avenue Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2000 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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Baltimore, Maryland 21215-0020

Box 68760

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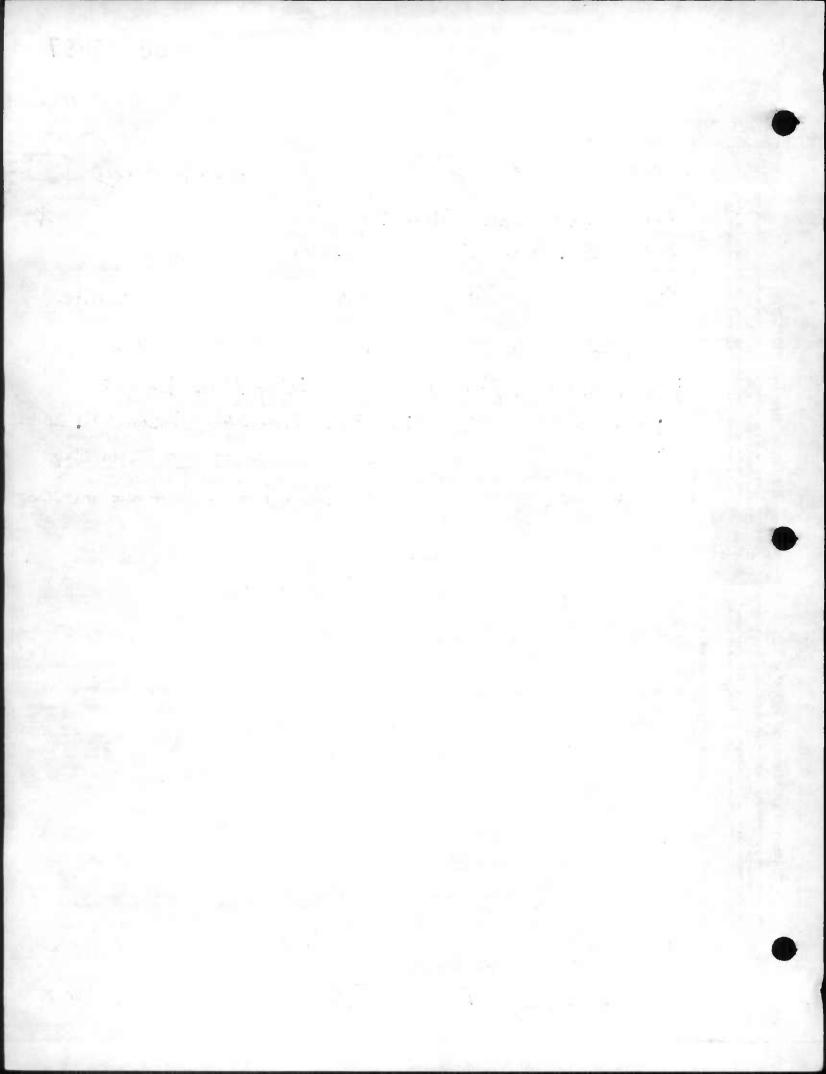
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To the Vithin 2

rof-death (Item 23a) (Type, Print)

32. Registral's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month BERTRAN FEBRUARY 26, 2000 8:30 PM 4e Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) Days Hours 1 MM 2 F 218-14-7173 Usuel Residence of Decedent Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code de 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian, Bleck, White, etc. 1 ☐ Never Merried 2 Merried 2 No 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Yaar or Detas: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry lephone Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State Zip Code) Himore March 20b. Plece of Disposition (Name of cametery, crametory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ⊠Buriel 2 □ Cremetion 3 □ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) emoter 21. Signeture of Funerel Service Licenses 22. Name and Address of Fecility & vans Hal 234 Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth ACUTE CEREBROVASCULAR ACCIDENT Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of) AGITATED BEHAVIOUR Due to (or es a consequenca of) VASCULAR DEMENTIA Due to (or es a consequance of): CHRONIC ATRIAL FIBRILLATION 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes

Physician /Medical **Examiner** 

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Records, P.O.

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Division Attending **Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

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Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in death) Last Physician/Medical

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26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

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28c. tnjury et Work? 1 Yas 2 No Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homicide

1/2 Scriffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signatura and title of certifier

25. Was case referred to medical axaminer?

29c. License number D25886

29d. Dete signed (Month, Day, Year) 2000 reb

30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

7601 OSLER DRIVE TOWSON, MARYLAND 21204 LILIA CEBALLOS M. D.

State Registrar

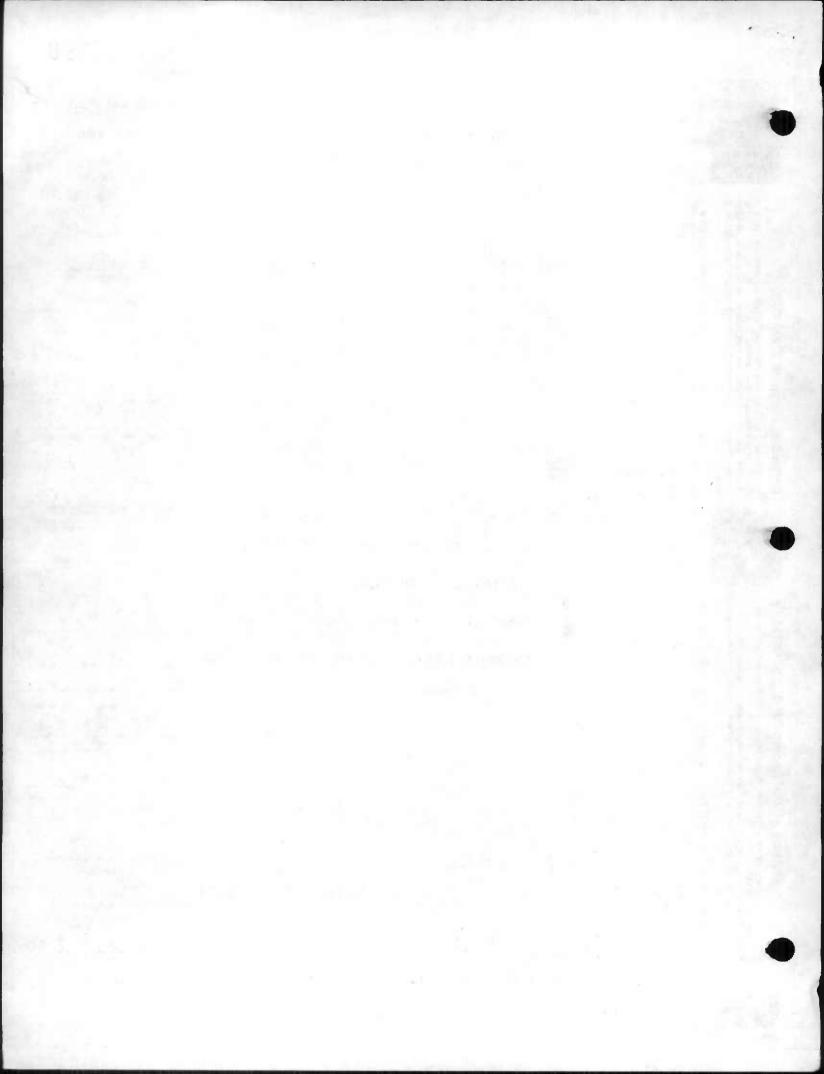
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**DHMH 16 Rev 6/95** 



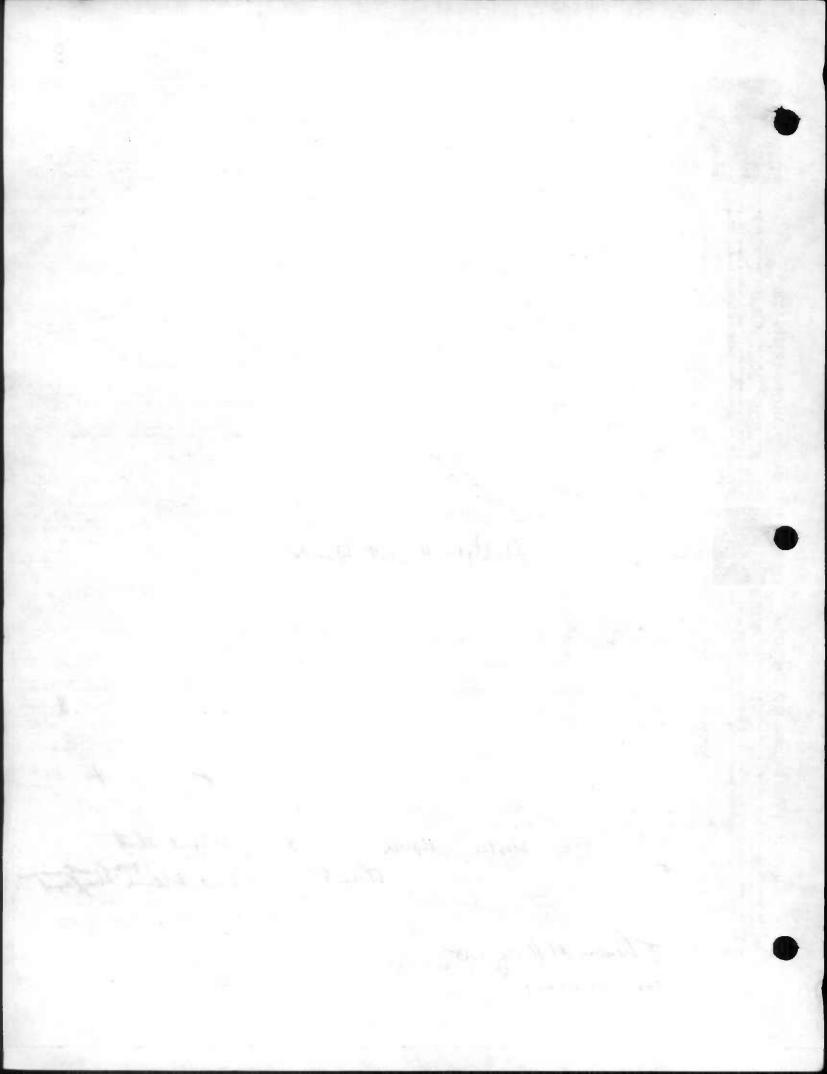
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State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** LIONEL CLEMENT BERGERON 1:00 AM /Medical FEBRUARY 28 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 636 TIMOTHY DRIVE LINTHICUM ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days HZM 2□ F Months Hours 017-01-9371 Yrs. 81 Director MARCH 16,1918 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at MARYLAND ANNE ARUNDEL LINTHICUM 1 ☐ Yes 2 No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 636 TIMOTHY DRIVE 21090 U.S.A. Norma 23a 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 12 Yes 2 No 1944-If Yes, Give Year or Dates: 1946 21215-0020 ò 1 Yes 2√ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HUMAN RESOURCE DEPT. I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SUPERINTENDENT OF SUGGESTIONS WESTINGHOUSE 12 Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fitted in ment of Heelth and Mental Hant: If Item 27 Ia marked oth lury or other treumatic even LAWRENCE YVONNE N. BERGERON BLANCHARD 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) 636 TIMOTHY DRIVE, LINTHICUM, MD. 21090 MRS. YVETTE HELEN BERGERON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata MAR. 2. Burial 2 Cemation 3 Removal from State 4 Donation 5 4 Other (Specify) Department of Important: If eny injury or page. MEADOWRIDGE MEMORIAL PARK! 2000 ELKRIDGE, MD. 21. Signature of Fangral Se 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause or each line. Onset and Death **Physician** congashre heart failure Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? April fimilaha 1 Yes 2 N6 3 Probably 4 Unknown Records, ð 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed [ rehorsepells this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. Be 25. Was case referred to medical axaminer? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Passidence 6 ☐ Other (Specify) edical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) funeral 27. Manney of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Division 1 Natural s after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb 28, 2000 D23624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 S Crain Hwy #306 GHERBURNIE MD 21061 Basan + Khandelwal mo 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 2 9 2000

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**ORIGINAL** 

